

***United States Court of Appeals
for the Second Circuit***



APPENDIX

77-7102, 7114

United States Court of Appeals FOR THE SECOND CIRCUIT

Docket Nos. 77-7102 and 77-7114

NEW YORK ASSOCIATION OF HOMES
FOR AGING, et al.,

Plaintiffs-Appellants,

against

PHILIP L. TOLA, as Commissioner of Social Services
of the State of New York, et al.,

Defendants-Appellees.

JOSEPH BULLA, et al.,

Plaintiffs-Appellants,

against

PHILIP L. TOLA, as Commissioner of Social Services
of the State of New York, et al.,

Defendants-Appellees.

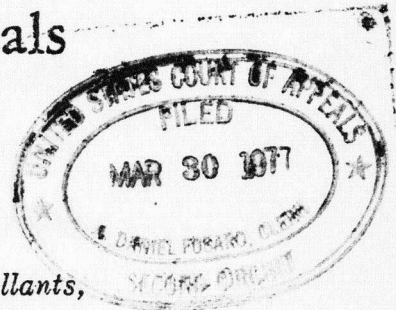
APPEALS FROM ORDERS OF THE UNITED STATES DISTRICT
COURT FOR THE SOUTHERN DISTRICT OF NEW YORK

STATUTES, REGULATIONS AND UNREPORTED
DECISIONS RELEVANT TO THE APPEAL

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42 U.S.C. §1396 et seq. (The Medicaid Act)

SUBCHAPTER XIX—GRANTS TO STATES FOR MEDICAL ASSISTANCE PROGRAMS

§ 1396. Authorization of appropriations

For the purpose of enabling each State, as far as practicable under the conditions in such State, to furnish (1) medical assistance on behalf of families with dependent children and of aged, blind, or disabled individuals, whose income and resources are insufficient to meet the costs of necessary medical services, and (2) rehabilitation and other services to help such families and individuals attain or retain capability for independence or self-care, there is hereby authorized to be appropriated for each fiscal year a sum sufficient to carry out the purposes of this subchapter. The sums made available under this section shall be used for making payments to States which have submitted, and had approved by the Secretary of Health, Education, and Welfare, State plans for medical assistance. Aug. 14, 1935, c. 531, Title XIX, § 1901, as added July 30, 1965, Pub. L. 89-97, Title I, § 121(a), 79 Stat. 343, and amended Dec. 31, 1973, Pub.L. 93-233, § 13(a)(1), 87 Stat. 960.

Historical Note

1973 Amendment. Pub.L. 93-233 substituted in item (1) "disabled individuals" for "permanently and totally disabled individuals".

commencing after Dec. 31, 1973, see section 13(d) of Pub.L. 93-233, set out as a note under section 1396a of this title.

Effective Date of 1973 Amendment. Amendment by Pub.L. 93-233 effective with respect to payments under section 1396b of this title for calendar quarters

Legislative History. For legislative history and purpose of Pub.L. 89-97, see 1965 U.S.Code Cong. and Adm.News, p. 1943. See, also, Pub.L. 93-233, 1973 U.S. Code Cong. and Adm.News, p. 3177.

Library References

Social Security and Public Welfare
§ 241.
United States § 82.

C.J.S. Social Security and Public Welfare § 73.
C.J.S. United States § 122.

§ 1396a. State plans for medical assistance—Contents

(a) A State plan for medical assistance must—

(1) provide that it shall be in effect in all political subdivisions of the State, and, if administered by them, be mandatory upon them;

(2) provide for financial participation by the State equal to not less than 40 per centum of the non-Federal share of the expenditures under the plan with respect to which payments under section 1396b of this title are authorized by this subchapter; and, effective July 1, 1969, provide for financial participation by the State equal to all of such non-Federal share or provide for distribution of funds from Federal or State sources,

for carrying out the State plan, on an equalization or other basis which will assure that the lack of adequate funds from local sources will not result in lowering the amount, duration, scope, or quality of care and services available under the plan;

(3) provide for granting an opportunity for a fair hearing before the State agency to any individual whose claim for medical assistance under the plan is denied or is not acted upon with reasonable promptness;

(4) provide (A) such methods of administration (including methods relating to the establishment and maintenance of personnel standards on a merit basis, except that the Secretary shall exercise no authority with respect to the selection, tenure of office, and compensation of any individual employed in accordance with such methods, and including provision for utilization of professional medical personnel in the administration and, where administered locally, supervision of administration of the plan) as are found by the Secretary to be necessary for the proper and efficient operation of the plan, and (B) for the training and effective use of paid subprofessional staff with particular emphasis on the full-time or part-time employment of recipients and other persons of low income, as community service aides, in the administration of the plan and for the use of nonpaid or partially paid volunteers in a social service volunteer program in providing services to applicants and recipients and in assisting any advisory committees established by the State agency;

(5) either provide for the establishment or designation of a single State agency to administer or to supervise the administration of the plan; or provide for the establishment or designation of a single State agency to administer or to supervise the administration of the plan, except that the determination of eligibility for medical assistance under the plan shall be made by the State or local agency administering the State plan approved under subchapter I or XVI of this chapter (insofar as it relates to the aged) if the State is eligible to participate in the State plan program established under subchapter XVI of this chapter, or by the agency or agencies administering the supplemental security income program established under subchapter XVI or the State plan approved under part A of subchapter IV of this chapter if the State is not eligible to participate in the State plan program established under subchapter XVI of this chapter;

(6) provide that the State agency will make such reports, in such form and containing such information, as the Secretary may from time to time require, and comply with such provisions as the Secretary may from time to time find necessary to assure the correctness and verification of such reports;

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(7) provide safeguards which restrict the use or disclosure of information concerning applicants and recipients to purposes directly connected with the administration of the plan;

(8) provide that all individuals wishing to make application for medical assistance under the plan shall have opportunity to do so, and that such assistance shall be furnished with reasonable promptness to all eligible individuals;

(9) provide—

(A) that the State health agency, or other appropriate State medical agency (whichever is utilized by the Secretary for the purpose specified in the first sentence of section 1395aa(a) of this title), shall be responsible for establishing and maintaining health standards for private or public institutions in which recipients of medical assistance under the plan may receive care or services, and

(B) for the establishment or designation of a State authority or authorities which shall be responsible for establishing and maintaining standards, other than those relating to health, for such institutions;

(10) provide—

(A) for making medical assistance available to all individuals receiving aid or assistance under any plan of the State approved under subchapter I, X, XIV, or XVI, or part A of subchapter IV of this chapter, or with respect to whom supplemental security income benefits are being paid under subchapter XVI of this chapter;

(B) that the medical assistance made available to any individual described in clause (A)—

(i) shall not be less in amount, duration, or scope than the medical assistance made available to any other such individual, and

(ii) shall not be less in amount, duration, or scope than the medical assistance made available to individuals not described in clause A; and

(C) if medical assistance is included for any group of individuals who are not described in clause (A) and who do not meet the income and resources requirements of the appropriate State plan, or the supplemental security income program under subchapter XVI of this chapter, as the case may be, as determined in accordance with standards prescribed by the Secretary—

(i) for making medical assistance available to all individuals who would, except for income and resources, be eligible for aid or assistance under any such State plan or to have paid with respect to them supplemental

security income benefits under subchapter XVI of this chapter, and who have insufficient (as determined in accordance with comparable standards) income and resources to meet the costs of necessary medical and remedial care and services, and

(ii) that the medical assistance made available to all individuals not described in clause (A) shall be equal in amount, duration, and scope;

except that (I) the making available of the services described in paragraph (4), (14), or (16) of section 1396d(a) of this title to individuals meeting the age requirements prescribed therein shall not, by reason of this paragraph (10), require the making available of any such services, or the making available of such services of the same amount, duration, and scope, to individuals of any other ages, (II) the making available of supplementary medical insurance benefits under part B of subchapter XVIII of this chapter to individuals eligible therefor (either pursuant to an agreement entered into under section 1395v of this title or by reason of the payment of premiums under such subchapter by the State agency on behalf of such individuals), or provision for meeting part or all of the cost of deductibles, cost sharing, or similar charges under part B of subchapter XVIII of this chapter for individuals eligible for benefits under such part, shall not, by reason of this paragraph (10), require the making available of any such benefits, or the making available of services of the same amount, duration, and scope, to any other individuals, and (III) the making available of medical assistance equal in amount, duration, and scope to the medical assistance made available to individuals described in clause (A) to any classification of individuals approved by the Secretary, with respect to whom there is being paid, or who are eligible, or would be eligible if they were not in a medical institution, to have paid with respect to them, a State supplementary payment shall not, by reason of this paragraph (10), require the making available of any such assistance, or the making available of such assistance of the same amount, duration, and scope, to any other individuals not described in clause (A);

(11)(A) provide for entering into cooperative arrangements with the State agencies responsible for administering or supervising the administration of health services and vocational rehabilitation services in the State looking toward maximum utilization of such services in the provision of medical assistance under the plan, and (B) effective July 1, 1969, provide, to the extent prescribed by the Secretary, for entering into agreements, with any agency, institution, or organization receiving payments for part or all of the cost of plans or projects under subchapter V of this chapter, (i) providing for utilizing such

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agency, institution, or organization in furnishing care and serv-
ices which are available under such plan or project under sub-
chapter V of this chapter and which are included in the State
plan approved under this section and (ii) making such provi-
sion as may be appropriate for reimbursing such agency, insti-
tution, or organization for the cost of any such care and serv-
ices furnished any individual for which payment would other-
wise be made to the State with respect to him under section
1396b of this title;

(12) provide that, in determining whether an individual is
blind, there shall be an examination by a physician skilled in
the diseases of the eye or by an optometrist, whichever the indi-
vidual may select;

(13) provide—

(A)(i) for the inclusion of some institutional and some
noninstitutional care and services, and

(ii) for the inclusion of home health services for any in-
dividual who, under the State plan, is entitled to skilled
nursing facility services, and

(B) in the case of individuals receiving aid or assistance
under any plan of the State approved under subchapter I,
X, XIV, or XVI, or part A of subchapter IV of this chapter,
or with respect to whom supplemental security income ben-
efits are being paid under subchapter XVI of this chapter,
for the inclusion of at least the care and services listed in
clauses (1) through (5) of section 1396d(a) of this title,
and

(C) in the case of individuals not included under subpara-
graph (B) for the inclusion of at least—

(i) the care and services listed in clauses (1)
through (5) of section 1396d(a) of this title or

(ii)(I) the care and services listed in any 7 of the
clauses numbered (1) through (16) of such section and
(II) in the event the care and services provided under
the State plan include hospital or skilled nursing facil-
ity services, physicians' services to an individual in a
hospital or skilled nursing facility during any period
he is receiving hospital services from such hospital or
skilled nursing facility services from such facility, and

(D) for payment of the reasonable cost of inpatient hos-
pital services provided under the plan, as determined in ac-
cordance with methods and standards, consistent with sec-
tion 1320a-1 of this title, which shall be developed by the
State and reviewed and approved by the Secretary and
(after notice of approval by the Secretary) included in the
plan, except that the reasonable cost of any such services

as determined under such methods and standards shall not exceed the amount which would be determined under section 1395x(v) of this title as the reasonable cost of such services for purposes of subchapter XVIII of this chapter; and

(E) effective July 1, 1976, for payment of the skilled nursing facility and intermediate care facility services provided under the plan on a reasonable cost related basis, as determined in accordance with methods and standards which shall be developed by the State on the basis of cost-finding methods approved and verified by the Secretary;

(14) effective January 1, 1973, provide that—

(A) in the case of individuals receiving aid or assistance under any plan of the State approved under subchapter I, X, XIV, or XVI, or part A of subchapter IV of this chapter, or with respect to whom supplemental security income benefits are being paid under subchapter XVI of this chapter, or who meet the income and resources requirements of the appropriate State plan, or the supplemental security income program under subchapter XVI of this chapter, as the case may be, and individuals with respect to whom there is being paid, or who are eligible, or would be eligible if they were not in a medical institution, to have paid with respect to them, a State supplementary payment and are eligible for medical assistance equal in amount, duration, and scope to the medical assistance made available to individuals described in paragraph (10)(A)—

(i) no enrollment fee, premium, or similar charge, and no deduction, cost sharing, or similar charge with respect to the care and services listed in clauses (1) through (5) and (7) of section 1396d(a) of this title, will be imposed under the plan, and

(ii) any deduction, cost sharing, or similar charge imposed under the plan with respect to other care and services will be nominal in amount (as determined in accordance with standards approved by the Secretary and included in the plan), and

(B) with respect to individuals (other than individuals with respect to whom there is being paid, or who are eligible or would be eligible if they were not in a medical institution, to have paid with respect to them, a State supplementary payment and are eligible for medical assistance equal in amount, duration, and scope to the medical assistance made available to individuals described in paragraph (10)(A)) who are not receiving aid or assistance under any such State plan and with respect to whom supplemental se-

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and standards shall not be determined under reasonable cost of such XVIII of this chapter;

payment of the skilled nursing facility services provided on a cost related basis, as methods and standards are on the basis of cost-estimated by the Secretary; that —

giving aid or assistance provided under subchapter I, chapter IV of this chapter, supplemental security income benefits requirements of the supplemental security income program of this chapter, as the case may be, to whom there is no charge should be eligible if they have paid with respect to the amount, duration, and scope of the services available to individuals de-

um, or similar charge, or similar charge with those listed in clauses (1) and (2) of § 1396d(a) of this title, and

ring, or similar charge with respect to other care and treatment (as determined in accordance with standards approved by the Secretary

(other than individuals who are not paid, or who are eligible for medical assistance under a State supplement to the medical assistance program described in paragraph (b) of this section, or assistance under any other program to whom supplemental se-

curity income benefits are not being paid under subchapter XVI of this chapter and who do not meet the income and resources requirements of the appropriate State plan, or the supplemental security income program under subchapter XVI of this chapter, as the case may be—

(i) there may be imposed an enrollment fee, premium, or similar charge which (as determined in accordance with standards prescribed by the Secretary) is related to the individual's income, and

(ii) any deductible, cost-sharing, or similar charge imposed under the plan will be nominal;

(15) in the case of eligible individuals 65 years of age or older who are covered by either or both of the insurance programs established by subchapter XVIII of this chapter, provide where, under the plan, all of any deductible, cost sharing, or similar charge imposed with respect to such individual under the insurance program established by such subchapter is not met, the portion thereof which is met shall be determined on a basis reasonably related (as determined in accordance with standards approved by the Secretary and included in the plan) to such individual's income or his income and resources;

(16) provide for inclusion, to the extent required by regulations prescribed by the Secretary, of provisions (conforming to such regulations) with respect to the furnishing of medical assistance under the plan to individuals who are residents of the State but are absent therefrom;

(17) include reasonable standards (which shall be comparable for all groups and may, in accordance with standards prescribed by the Secretary, differ with respect to income levels, but only in the case of applicants or recipients of assistance under the plan who are not receiving aid or assistance under any plan of the State approved under subchapter I, X, XIV, or XVI, or part A of subchapter IV of this chapter, and with respect to whom supplemental security income benefits are not being paid under subchapter XVI of this chapter based on the variations between shelter costs in urban areas and in rural areas) for determining eligibility for and the extent of medical assistance under the plan which (A) are consistent with the objectives of this subchapter, (B) provide for taking into account only such income and resources as are, as determined in accordance with standards prescribed by the Secretary, available to the applicant or recipient and (in the case of any applicant or recipient who would, except for income and resources, be eligible for aid or assistance in the form of money payments under any plan of the State approved under subchapter I, X, XIV, or XVI, or part A of subchapter IV, or to have paid with respect to him supplemental security income benefits under subchapter XVI of this

chapter as would not be disregarded (or set aside for future needs) in determining his eligibility for such aid, assistance, or benefits, (C) provide for reasonable evaluation of any such income or resources, and (D) do not take into account the financial responsibility of any individual for any applicant or recipient of assistance under the plan unless such applicant or recipient is such individual's spouse or such individual's child who is under age 21 or (with respect to States eligible to participate in the State program established under subchapter XVI of this chapter), is blind or permanently and totally disabled, or is blind or disabled as defined in section 1382c of this title (with respect to States which are not eligible to participate in such program); and provide for flexibility in the application of such standards with respect to income by taking into account, except to the extent prescribed by the Secretary, the costs (whether in the form of insurance premiums or otherwise) incurred for medical care or for any other type of remedial care recognized under State law;

(18) provide that no lien may be imposed against the property of any individual prior to his death on account of medical assistance paid or to be paid on his behalf under the plan (except pursuant to the judgment of a court on account of benefits incorrectly paid on behalf of such individual), and that there shall be no adjustment or recovery (except, in the case of an individual who was 65 years of age or older when he received such assistance, from his estate, and then only after the death of his surviving spouse, if any, and only at a time when he has no surviving child who is under age 21 or (with respect to States eligible to participate in the State program established under subchapter XVI of this chapter), is blind or permanently and totally disabled, or is blind or disabled as defined in section 1382c of this title (with respect to States which are not eligible to participate in such program)) of any medical assistance correctly paid on behalf of such individual under the plan;

(19) provide such safeguards as may be necessary to assure that eligibility for care and services under the plan will be determined, and such care and services will be provided in a manner consistent with simplicity of administration and the best interests of the recipients;

(20) if the State plan includes medical assistance in behalf of individuals 65 years of age or older who are patients in institutions for mental diseases—

(A) provide for having in effect such agreements or other arrangements with State authorities concerned with mental diseases, and, where appropriate, with such institutions, as may be necessary for carrying out the State plan, including arrangements for joint planning and for develop-

et aside for future aid, assistance, or tion of any such in- account the finan- applicant or recipi- applicant or recipi- ividual's child who is ble to participate in chapter XVI of this ally disabled, or is c of this title (with participate in such e application of such into account, except he costs (whether in rwise) incurred for edial care recognized

d against the proper- count of medical as- der the plan (except count of benefits in- al), and that there in the case of an in- er when he received only after the death t a time when he has or (with respect to program established blind or permanently as defined in section which are not eligible edical assistance cor- er the plan;

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ment of alternate methods of care, arrangements providing assurance of immediate readmittance to institutions where needed for individuals under alternate plans of care, and arrangements providing for access to patients and facilities, for furnishing information, and for making reports;

(B) provide for an individual plan for each such patient to assure that the institutional care provided to him is in his best interests, including, to that end, assurances that there will be initial and periodic review of his medical and other needs, that he will be given appropriate medical treatment within the institution, and that there will be a periodical determination of his need for continued treatment in the institution;

(C) provide for the development of alternate plans of care, making maximum utilization of available resources, for recipients 65 years of age or older who would otherwise need care in such institutions, including appropriate medical treatment and other aid or assistance; for services referred to in section 303(a)(4)(A)(i) and (ii), section 803(a)(1)(A)(i) and (ii) of this title or section 1383(a)(4)(A)(i) and (ii) of this title which are appropriate for such recipients and for such patients; and for methods of administration necessary to assure that the responsibilities of the State agency under the State plan with respect to such recipients and such patients will be effectively carried out; and

(D) provide methods of determining the reasonable cost of institutional care for such patients;

(21) if the State plan includes medical assistance in behalf of individuals 65 years of age or older who are patients in public institutions for mental diseases, show that the State is making satisfactory progress toward developing and implementing a comprehensive mental health program, including provision for utilization of community mental health centers, nursing facilities, and other alternatives to care in public institutions for mental diseases;

(22) include descriptions of (A) the kinds and numbers of professional medical personnel and supporting staff that will be used in the administration of the plan and of the responsibilities they will have, (B) the standards, for private or public institutions in which recipients of medical assistance under the plan may receive care or services, that will be utilized by the State authority or authorities responsible for establishing and maintaining such standards, (C) the cooperative arrangements with State health agencies and State vocational rehabilitation agencies entered into with a view to maximum utilization of and coordination of the provision of medical assistance with the

services administered or supervised by such agencies, and (D) other standards and methods that the State will use to assure that medical or remedial care and services provided to recipients of medical assistance are of high quality;

(23) provide that any individual eligible for medical assistance (including drugs) may obtain such assistance from any institution, agency, community pharmacy, or person, qualified to perform the service or services required (including an organization which provides such services, or arranges for their availability, on a prepayment basis), who undertakes to provide him such services; and a State plan shall not be deemed to be out of compliance with the requirements of this paragraph or paragraph (1) or (10) solely by reason of the fact that the State (or any political subdivision thereof) has entered into a contract with an organization which has agreed to provide care and services in addition to those offered under the State plan to individuals eligible for medical assistance who reside in the geographic area served by such organization and who elect to obtain such care and services from such organization;

(24) effective July 1, 1969, provide for consultative services by health agencies and other appropriate agencies of the State to hospitals, nursing facilities, home health agencies, clinics, laboratories, and such other institutions as the Secretary may specify in order to assist them (A) to qualify for payments under this chapter, (B) to establish and maintain such fiscal records as may be necessary for the proper and efficient administration of this chapter, and (C) to provide information needed to determine payments due under this chapter on account of care and services furnished to individuals;

(25) provide (A) that the State or local agency administering such plan will take all reasonable measures to ascertain the legal liability of third parties to pay for care and services (available under the plan) arising out of injury, disease, or disability, (B) that where the State or local agency knows that a third party has such a legal liability such agency will treat such legal liability as a resource of the individual on whose behalf the care and services are made available for purposes of paragraph (17)(B), and (C) that in any case where such a legal liability is found to exist after medical assistance has been made available on behalf of the individual, the State or local agency will seek reimbursement for such assistance to the extent of such legal liability;

(26) effective July 1, 1969, provide (A) for a regular program of medical review (including medical evaluation) of each patient's need for skilled nursing facility care or (in the case of individuals who are eligible therefor under the State plan) need for care in a mental hospital, a written plan of care, and, where

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applicable, a plan of rehabilitation prior to admission to a
skilled nursing facility; (B) for periodic inspections to be
made in all skilled nursing facilities and mental institutions (if
the State plan includes care in such institutions) within the
State by one or more medical review teams (composed of physi-
cians and other appropriate health and social service person-
nel) of (i) the care being provided in such nursing facilities
(and mental institutions, if care therein is provided under the
State plan) to persons receiving assistance under the State
plan, (ii) with respect to each of the patients receiving such
care, the adequacy of the services available in particular nurs-
ing facilities (or institutions) to meet the current health needs
and promote the maximum physical well-being of patients re-
ceiving care in such facilities (or institutions), (iii) the neces-
sity and desirability of the continued placement of such pa-
tients in such nursing facilities (or institutions), and (iv) the
feasibility of meeting their health care needs through alterna-
tive institutional or noninstitutional services; and (C) for the
making by such team or teams of full and complete reports of
the findings resulting from such inspections together with any
recommendations to the State agency administering or supervising
the administration of the State plan;

(27) provide for agreements with every person or institution
providing services under the State plan under which such per-
son or institution agrees (A) to keep such records as are neces-
sary fully to disclose the extent of the services provided to indi-
viduals receiving assistance under the State plan, and (B) to
furnish the State agency with such information, regarding any
payments claimed by such person or institution for providing
services under the State plan, as the State agency may from
time to time request;

(28) provide that any skilled nursing facility receiving pay-
ments under such plan must satisfy all of the requirements con-
tained in section 1395x(j) of this title, except that the exclusion
contained therein with respect to institutions which are primar-
ily for the care and treatment of mental diseases and tuberculo-
sis shall not apply for purposes of this title;

(A) supply to the licensing agency of the State full and
complete information as to the identity (i) of each person
having (directly or indirectly) an ownership interest of 10
per centum or more in such nursing home, (ii) in case a
nursing home is organized as a corporation, of each officer
and director of the corporation, and (iii) in case a nursing
home is organized as a partnership, of each partner; and
promptly report any changes which would affect the cur-
rent accuracy of the information so required to be sup-
plied;

(B) have and maintain an organized nursing service for its patients, which is under the direction of a professional registered nurse who is employed full-time by such nursing home, and which is composed of sufficient nursing and auxiliary personnel to provide adequate and properly supervised nursing services for such patients during all hours of each day and all days of each week;

(C) make satisfactory arrangements for professional planning and supervision of menus and meal service for patients for whom special diets or dietary restrictions are medically prescribed;

(D) have satisfactory policies and procedures relating to the maintenance of medical records on each patient of the nursing home, dispensing and administering of drugs and biologicals, and assuring that each patient is under the care of a physician and that adequate provisions is made for medical attention to any patient during emergencies;

(E) have arrangements with one or more general hospitals under which such hospital or hospitals will provide needed diagnostic and other services to patients of such nursing home, and under which such hospital or hospitals agree to timely acceptance, as patients thereof, of acutely ill patients of such nursing home who are in need of hospital care; except that the State Agency may waive this requirement wholly or in part with respect to any nursing home meeting all the other requirements and which, by reason of remote location or other good and sufficient reason, is unable to effect such an arrangement with a hospital; and

(F)(i) meet (after December 31, 1969) such provisions of the Life Safety Code of the National Fire Protection Association (21st Edition, 1967) as are applicable to nursing homes; except that the State agency may waive in accordance with regulations of the Secretary, for such periods as it deems appropriate, specific provisions of such code which, if rigidly applied, would result in unreasonable hardship upon a nursing home, but only if such agency makes a determination (and keeps a written record setting forth the basis of such determination) that such waiver will not adversely affect the health and safety of the patients of such skilled nursing home; and except that the requirements set forth in the preceding provisions of this subclause (i) shall not apply in any State if the Secretary finds that in such State there is in effect a fire and safety code, imposed by State law, which adequately protects patients in nursing homes; and (ii) meet conditions relating to environment and sanitation applicable to extended care

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facilities under subchapter XVIII of this chapter; except that the State agency may waive in accordance with regulations of the Secretary, for such periods as it deems appropriate, any requirement imposed by the preceding provisions of this subclause (ii) if such agency finds that such requirement, if rigidly applied, would result in unreasonable hardship upon a nursing home, but only if such agency makes a determination (and keeps a written record setting forth the basis of such determination) that such waiver will not adversely affect the health and safety of the patients of such nursing home;

(29) include a State program which meets the requirements set forth in section 1396g of this title, for the licensing of administrators of nursing homes;

(30) provide such methods and procedures relating to the utilization of, and the payment for, care and services available under the plan (including but not limited to utilization review plans as provided for in section 1396b(i)(4) of this title) as may be necessary to safeguard against unnecessary utilization of such care and services and to assure that payments (including payments for any drugs provided under the plan) are not in excess of reasonable charges consistent with efficiency, economy, and quality of care;

(31) provide (A) for a regular program of independent professional review (including medical evaluation of each patient's need for intermediate care) and a written plan of service prior to admission or authorization of benefits in an intermediate care facility as determined under regulations of the Secretary; (B) for periodic on-site inspections to be made in all such intermediate care facilities (if the State plan includes care in such institutions) within the State by one or more independent professional review teams (composed of physicians or registered nurses and other appropriate health and social service personnel) of (i) the care being provided in such intermediate care facilities to persons receiving assistance under the State plan, (ii) with respect to each of the patients receiving such care, the adequacy of the services available in particular intermediate care facilities to meet the current health needs and promote the maximum physical well-being of patients receiving care in such facilities, (iii) the necessity and desirability of the continued placement of such patients in such facilities, and (iv) the feasibility of meeting their health care needs through alternative institutional or non-institutional services; and (C) for the making by such team or teams of full and complete reports of the findings resulting from such inspections, together with any recommendations to the State agency administering or supervising the administration of the State plan;

(32) provide that no payment under the plan for any care or service provided to an individual by a physician, dentist, or other individual practitioner shall be made to anyone other than such individual or such physician, dentist, or practitioner, except that payment may be made (A) to the employer of such physician, dentist, or practitioner if such physician, dentist, or practitioner is required as a condition of his employment to turn over his fee for such care or service to his employer, or (B) (where the care or service was provided in a hospital, clinic, or other facility) to the facility in which the care or service was provided if there is a contractual arrangement between such physician, dentist, or practitioner and such facility under which such facility submits the bill for such care or service;

(33) provide—

(A) that the State health agency, or other appropriate State medical agency, shall be responsible for establishing a plan, consistent with regulations prescribed by the Secretary, for the review by appropriate professional health personnel of the appropriateness and quality of care and services furnished to recipients of medical assistance under the plan in order to provide guidance with respect thereto in the administration of the plan to the State agency established or designated pursuant to paragraph (5) and, where applicable, to the State agency described in the penultimate sentence of this subsection; and

(B) that the State or local agency utilized by the Secretary for the purpose specified in the first sentence of section 1395aa(a) of this title, or, if such agency is not the State agency which is responsible for licensing health institutions, the State agency responsible for such licensing, will perform for the State agency administering or supervising the administration of the plan approved under this title the function of determining whether institutions and agencies meet the requirements for participation in the program under such plan;

(34) provide that in the case of any individual who has been determined to be eligible for medical assistance under the plan, such assistance will be made available to him for care and services included under the plan and furnished in or after the third month before the month in which he made application (or application was made on his behalf in the case of a deceased individual) for such assistance if such individual was (or upon application would have been) eligible for such assistance at the time such care and services were furnished;

(35) effective January 1, 1973, provide that any intermediate care facility or who is the owner (in whole or in part) of any mortgage, deed of trust, note, or other obligation secured (in

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whole or in part) by such intermediate care facility or any of the property or assets of such intermediate care facility receiving payments under such plan must supply to the licensing agency of the State full and complete information as to the identity (A) of each person having (directly or indirectly) an ownership interest of 10 per centum or more in such intermediate care facility, (B) in case an intermediate care facility is organized as a corporation, of each officer and director of the corporation, and (C) in case an intermediate care facility is organized as a partnership, of each partner; and promptly report any changes which would affect the current accuracy of the information so required to be supplied; and

(36) provide that within 90 days following the completion of each survey of any health care facility, laboratory, agency, clinic, or organization, by the appropriate State agency described in paragraph (9), such agency shall (in accordance with regulations of the Secretary) make public in readily available form and place the pertinent findings of each such survey relating to the compliance of each such health care facility, laboratory, clinic, agency, or organization with (A) the statutory conditions of participation imposed under this title, and (B) the major additional conditions which the Secretary finds necessary in the interest of health and safety of individuals who are furnished care or services by any such facility, laboratory, clinic, agency, or organization.

Notwithstanding paragraph (5), if on January 1, 1965, and on the date on which a State submits its plan for approval under this subchapter, the State agency which administered or supervised the administration of the plan of such State approved under subchapter X of this chapter (or subchapter XVI of this chapter, insofar as it relates to the blind) was different from the State agency which administered or supervised the administration of the State plan approved under subchapter I of this chapter (or subchapter XVI of this chapter, insofar as it relates to the aged), the State agency which administered or supervised the administration of such plan approved under subchapter X of this chapter (or subchapter XVI of this chapter, insofar as it relates to the blind) may be designated to administer or supervise the administration of the portion of the State plan for medical assistance which relates to blind individuals and a different State agency may be established or designated to administer or supervise the administration of the rest of the State plan for medical assistance; and in such case the part of the plan which each such agency administers, or the administration of which each such agency supervises, shall be regarded as a separate plan for purposes of this subchapter (except for purposes of paragraph (10)). For purposes of paragraphs (9)(A), (29), (31), and (33), and of section 1396b(i)(4) of this title, the terms "skilled nursing facility" and "nursing facility" do not include a Christian Science

42 § 1396a PUBLIC HEALTH AND WELFARE Ch. 7

sanatorium operated, or listed and certified, by the First Church of Christ, Scientist, Boston, Massachusetts.

Approval by Secretary

(b) The Secretary shall approve any plan which fulfills the conditions specified in subsection (a) of this section, except that he shall not approve any plan which imposes, as a condition of eligibility for medical assistance under the plan—

- (1) an age requirement of more than 65 years; or
- (2) effective July 1, 1967, any age requirement which excludes any individual who has not attained the age of 21 and is or would, except for the provisions of section 606(a)(2) of this title, be a dependent child under part A of subchapter IV of this chapter; or
- (3) any residence requirement which excludes any individual who resides in the State; or
- (4) any citizenship requirement which excludes any citizen of the United States.

Same; reduction of aid or assistance under State plans under other subchapters

(c) Notwithstanding subsection (b) of this section, the Secretary shall not approve any State plan for medical assistance if he determines that the approval and operation of the plan will result in a reduction in aid or assistance in the form of money payments (other than so much, if any, of the aid or assistance in such form as was, immediately prior to the effective date of the State plan under this subchapter, attributable to medical needs) provided for eligible individuals under a plan of such State approved under subchapter I, X, XIV, or XVI of this chapter, or part A of subchapter IV of this chapter.

(d) Repealed Pub.L. 92-603, Title II, § 231, Oct. 30, 1972, 86 Stat. 1410.

Continued eligibility of families determined ineligible because of income and resources or hours of work limitations of plan

(e) Notwithstanding any other provision of this subchapter, effective January 1, 1974, each State plan approved under this subchapter must provide that each family which was receiving aid pursuant to a plan of the State approved under part A of subchapter IV of this chapter in at least 3 of the 6 months immediately preceding the month in which such family became ineligible for such aid because of increased hours of, or increased income from, employment, shall, while a member of such family is employed, remain eligible for assistance under the plan approved under this subchapter (as though the family was receiving aid under the plan approved under part A of subchapter IV of this chapter) for 4 calendar

Ch. 7 MEDICAL ASSISTANCE PROGRAMS 42 § 1396a

months beginning with the month in which such family became ineligible for aid under the plan approved under part A of subchapter IV of this chapter because of income and resources or hours of work limitations contained in such plan.

Effective date of State plan as determinative of duty of State to provide medical assistance to aged, blind, or disabled individuals

(f) Notwithstanding any other provision of this subchapter, except as provided in subsection (e) of this section, no State not eligible to participate in the State plan program established under subchapter XVI of this chapter shall be required to provide medical assistance to any aged, blind, or disabled individual (within the meaning of subchapter XVI of this chapter) for any month unless such State would be (or would have been) required to provide medical assistance to such individual for such month had its plan for medical assistance approved under this subchapter and in effect on January 1, 1972, been in effect in such month, except that for this purpose any such individual shall be deemed eligible for medical assistance under such State plan if (in addition to meeting such other requirements as are or may be imposed under the State plan) the income of any such individual as determined in accordance with section 1396b(f) of this title (after deducting any supplemental security income payment and State supplementary payment made with respect to such individual, and incurred expenses for medical care as recognized under State law) is not in excess of the standard for medical assistance established under the State plan as in effect on January 1, 1972. In States which provide medical assistance to individuals pursuant to clause (10)(C) of subsection (a) of this section, an individual who is eligible for medical assistance by reason of the requirements of this section concerning the deduction of incurred medical expenses from income shall be considered an individual eligible for medical assistance under clause (10)(A) of that subsection if that individual is, or is eligible to be (1) an individual with respect to whom there is payable a State supplementary payment on the basis of which similarly situated individuals are eligible to receive medical assistance equal in amount, duration, and scope to that provided to individuals eligible under clause (10)(A), or (2) an eligible individual or eligible spouse, as defined in subchapter XVI of this chapter, with respect to whom supplemental security income benefits are payable; otherwise that individual shall be considered to be an individual eligible for medical assistance under clause (10)(C) of that subsection. In States which do not provide medical assistance to individuals pursuant to clause (10)(C) of that subsection, an individual who is eligible for medical assistance by reason of the requirements of this section concerning the deduction of incurred medical expenses from income shall be considered an individual eligible for medical assistance under clause (10)(A) of that subsection.

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42 U.S.C. §§1395f(b) and 1395x(v) (Standards
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To the extent provided by regulations, the certification and recertification requirements of paragraph (2) shall be deemed satisfied where, at a later date, a physician makes certification of the kind provided in subparagraph (A), (B), (C), (D), or (E) of paragraph (2) (whichever would have applied), but only where such certification is accompanied by such medical and other evidence as may be required by such regulations.

Amount paid to provider of services

(b) The amount paid to any provider of services with respect to services for which payment may be made under this part shall, subject to the provisions of section 1395e of this title, be—

(1) the lesser of (A) the reasonable cost of such services, as determined under section 1395x(v) of this title, or (B) the customary charges with respect to such services; or

(2) if such services are furnished by a public provider of services free of charge or at nominal charges to the public, the amount determined on the basis of those items (specified in regulations prescribed by the Secretary) included in the determination of such reasonable cost which the Secretary finds will provide fair compensation to such provider for such services.

No payments to Federal providers of services

(c) No payment may be made under this part (except under subsection (d) of this section) to any Federal provider of services, except a provider of services which the Secretary determines is providing services to the public generally as a community institution or agency; and no such payment may be made to any provider of services for any item or service which such provider is obligated by a law of, or a contract with, the United States to render at public expense.

Payments for emergency hospital services

(d)(1) Payments shall also be made to any hospital for inpatient hospital services furnished in a calendar year, by the hospital or under arrangements (as defined in section 1395x(w) of this title) with it, to an individual entitled to hospital insurance benefits under section 426 of this title even though such hospital does not have an agreement in effect under this subchapter if (A) such services were emergency services, (B) the Secretary would be required to make such payment if the hospital had such an agreement in effect and otherwise met the conditions of payment hereunder, and (C) such hospital has elected to claim payments for all such inpatient emergency services and for the emergency outpatient services referred to in section 1395n(b) of this title furnished during such year. Such payments shall be made only in the amounts provided under subsection (b) of this section and then only if such hospital agrees to

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Provider of services

(u) The term "provider of services" means a hospital, skilled
nursing facility, or home health agency, or, for purposes of section
1395f(g) and section 1395n(c) of this title, a fund.

Reasonable cost; semi-private accommodations

(v)(1)(A) The reasonable cost of any services shall be the cost
actually incurred, excluding therefrom any part of incurred cost
found to be unnecessary in the efficient delivery of needed health
services, and shall be determined in accordance with regulations es-
tablishing the method or methods to be used, and the items to be in-
cluded, in determining such costs for various types or classes of in-
stitutions, agencies, and services; except that in any case to which
paragraph (2) or (3) applies, the amount of the payment deter-
mined under such paragraph with respect to the services involved
shall be considered the reasonable cost of such services. In pre-
scribing the regulations referred to in the preceding sentence, the
Secretary shall consider, among other things, the principles general-
ly applied by national organizations or established prepayment or-
ganizations (which have developed such principles) in computing
the amount of payment, to be made by persons other than the recipi-
ents of services, to providers of services on account of services fur-
nished to such recipients by such providers. Such regulations may
provide for determination of the costs of services on a per diem, per
unit, per capita, or other basis, may provide for using different
methods in different circumstances, may provide for the use of esti-
mates of costs of particular items or services, may provide for the
establishment of limits on the direct or indirect overall incurred
costs or incurred costs of specific items or services or groups of
items or services to be recognized as reasonable based on estimates
of the costs necessary in the efficient delivery of needed health
services to individuals covered by the insurance programs estab-
lished under this subchapter, and may provide for the use of
charges or a percentage of charges where this method reasonably
reflects the costs. Such regulations shall (i) take into account both
direct and indirect costs of providers of services (excluding there-
from any such costs, including standby costs, which are determined
in accordance with regulations to be unnecessary in the efficient de-
livery of services covered by the insurance programs established un-
der this subchapter) in order that, under the methods of determin-
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ices to individuals covered by the insurance programs established by
this subchapter will not be borne by individuals not so covered, and
the costs with respect to individuals not so covered will not be
borne by such insurance programs, and (ii) provide for the making

of suitable retroactive corrective adjustments where, for a provider of services for any fiscal period, the aggregate reimbursement produced by the methods of determining costs proves to be either inadequate or excessive.

(B) Such regulations in the case of extended care services furnished by proprietary facilities shall include provision for specific recognition of a reasonable return on equity capital, including necessary working capital, invested in the facility and used in the furnishing of such services, in lieu of other allowances to the extent that they reflect similar items. The rate of return recognized pursuant to the preceding sentence for determining the reasonable cost of any services furnished in any fiscal period shall not exceed one and one-half times the average of the rates of interest, for each of the months any part of which is included in such fiscal period, on obligations issued for purchase by the Federal Hospital Insurance Trust Fund.

(C) Where a hospital has an arrangement with a medical school under which the faculty of such school provides services at such hospital, an amount not in excess of the reasonable cost of such services to the medical school shall be included in determining the reasonable cost to the hospital of furnishing services—

(i) for which payment may be made under part A, but only if

(I) payment for such services as furnished under such arrangement would be made under part A to the hospital had such services been furnished by the hospital, and

(II) such hospital pays to the medical school at least the reasonable cost of such services to the medical school, or

(ii) for which payment may be made under part B, but only if such hospital pays to the medical school at least the reasonable cost of such services to the medical school.

(D) Where (i) physicians furnish services which are either inpatient hospital services (including services in conjunction with the teaching programs of such hospital) by reason of paragraph (7) of subsection (b) of this section or for which entitlement exists by reason of clause (II) of section 1395k(a)(2)(B)(i) and (ii) of this title such hospital (or medical school under arrangement with such hospital) incurs no actual cost in the furnishing of such services, the reasonable cost of such services shall (under regulations of the Secretary) be deemed to be the cost such hospital or medical school would have incurred had it paid a salary to such physicians rendering such services approximately equivalent to the average salary paid to all physicians employed by such hospital (or if such employment does not exist, or is minimal in such hospital, by similar hospitals in a geographic area of sufficient size to assure reasonable inclusion of sufficient physicians in development of such average salary).

(E) Such in any State which such skilled nursing provided under the increase a geographic area to the requirements of the computation of rates are analyses of facilities subpart of State if—

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(E) Such regulations may, in the case of skilled nursing facilities in any State, provide for the uses of rates, developed by the State in which such facilities are located, for the payment of the cost of skilled nursing facility services furnished under the State's plan approved under subchapter XIX of this chapter (and such rates may be increased by the Secretary on a class or size of institution or on a geographical basis by a percentage factor not in excess of 10 percent to take into account determinable items or services or other requirements under this subchapter not otherwise included in the computation of such State rates), if the Secretary finds that such rates are reasonably related to (but not necessarily limited to) analyses undertaken by such State of costs of care in comparable facilities in such State; except that the foregoing provisions of this subparagraph shall not apply to any skilled nursing facility in such State if—

(i) such facility is a distinct part of or directly operated by a hospital, or

(ii) such facility operates in a close, formal satellite relationship (as defined in regulations of the Secretary) with a participating hospital or hospitals.

Notwithstanding the previous provisions of this paragraph in the case of a facility specified in clause (ii) of this subparagraph, the reasonable cost of any services furnished by such facility as determined by the Secretary under this subsection shall not exceed 150 percent of the costs determined by the application of this subparagraph (without regard to such clause (ii)).

(2)(A) If the bed and board furnished as part of inpatient hospital services (including inpatient tuberculosis hospital services and inpatient psychiatric hospital services) or post-hospital extended care services is in accommodations more expensive than semi-private accommodations, the amount taken into account for purposes of payment under this subchapter with respect to such services may not exceed an amount equal to the reasonable cost of such services if furnished in such semi-private accommodations unless the more expensive accommodations were required for medical reasons.

(B) Where a provider of services which has an agreement in effect under this subchapter furnishes to an individual items or services which are in excess of or more expensive than the items or services with respect to which payment may be made under part A or part B, as the case may be, the Secretary shall take into account for purposes of payment to such provider of services only the equivalent of the reasonable cost of the items or services with respect to which such payment may be made.

(3) If the bed and board furnished as part of inpatient hospital services (including inpatient tuberculosis hospital services and inpatient psychiatric hospital services) or post-hospital extended care

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services is in accommodations other than, but not more expensive than, semi-private accommodations and the use of such other accommodations rather than semi-private accommodations was neither at the request of the patient nor for a reason which the Secretary determines is consistent with the purposes of this subchapter, the amount of the payment with respect to such bed and board under part A shall be the reasonable cost of such bed and board furnished in semi-private accommodations (determined pursuant to paragraph (1)) minus the difference between the charge customarily made by the hospital or skilled nursing facility for bed and board in semi-private accommodations and the charge customarily made by it for bed and board in the accommodations furnished.

(4) If a provider of services furnishes items or services to an individual which are in excess of or more expensive than the items or services determined to be necessary in the efficient delivery of needed health services and charges are imposed for such more expensive items or services under the authority granted in section 1395cc(a)(2)(B)(ii) of this title, the amount of payment with respect to such items or services otherwise due such provider in any fiscal period shall be reduced to the extent that such payment plus such charges exceed the cost actually incurred for such items or services in the fiscal period in which such charges are imposed.

(5)(A) Where physical therapy services, occupational therapy services, speech therapy services, or other therapy services or services of other health-related personnel (other than physicians) are furnished under an arrangement with a provider of services or other organization, specified in the first sentence of subsection (p) of this section the amount included in any payment to such provider or other organization under this subchapter as the reasonable cost of such services (as furnished under such arrangements) shall not exceed an amount equal to the salary which would reasonably have been paid for such services (together with any additional costs that would have been incurred by the provider or other organization) to the person performing them if they had been performed in an employment relationship with such provider or other organization (rather than under such arrangement) plus the cost of such other expenses (including a reasonable allowance for traveltime and other reasonable types of expense related to any differences in acceptable methods of organization for the provision of such therapy) incurred by such person, as the Secretary may in regulations determine to be appropriate.

(B) Notwithstanding the provisions of subparagraph (A), if a provider of services or other organization specified in the first sentence of subsection (p) of this section requires the services of a therapist on a limited part-time basis, or only to perform intermittent services, the Secretary may make payment on the basis of a reasonable rate per unit of service, even though such rate is greater

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per unit of time than salary related amounts, where he finds that such greater payment is, in the aggregate, less than the amount that would have been paid if such organization had employed a therapist on a full- or part-time salary basis.

(6) For purposes of this subsection, the term "semi-private accommodations" means two-bed, three-bed, or four-bed accommodations.

(7) For limitation on Federal participation for capital expenditures which are out of conformity with a comprehensive plan of a State or areawide planning agency, see section 1320a-1 of this title.

Arrangements for certain services

(w) The term "arrangements" is limited to arrangements under which receipt of payment by the hospital, skilled nursing facility, or home health agency (whether in its own right or as agent), with respect to services for which an individual is entitled to have payment made under this subchapter, discharges the liability of such individual or any other person to pay for the services.

State and United States

(x) The terms "State" and "United States" have the meaning given to them by subsections (h) and (i), respectively, of section 410 of this title.

Post-hospital extended care in Christian Science skilled nursing facilities

(y)(1) The term "skilled nursing facility" also includes a Christian Science sanatorium operated, or listed and certified, by the First Church of Christ, Scientist, Boston, Massachusetts, but only (except for purposes of subsection (a)(2) of this section) with respect to items and services ordinarily furnished by such an institution to inpatients, and payment may be made with respect to services provided by or in such an institution only to such extent and under such conditions, limitations, and requirements (in addition to or in lieu of the conditions, limitations, and requirements otherwise applicable) as may be provided in regulations.

(2) Notwithstanding any other provision of this subchapter, payment under part A may not be made for services furnished an individual in a skilled nursing facility to which paragraph (1) applies unless such individual elects, in accordance with regulations, for a spell of illness to have such services treated as post-hospital extended care services for purposes of such part; and payment under part A may not be made for post-hospital extended care services—

(A) furnished an individual during such spell of illness in a skilled nursing facility to which paragraph (1) applies after—

(i) such services have been furnished to him in such a facility for 30 days during such spell, or

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(ii) such services have been furnished to him during such spell in a skilled nursing facility to which such paragraph does not apply; or

(B) furnished an individual during such spell of illness in a skilled nursing facility to which paragraph (1) does not apply after such services have been furnished to him during such spell in a skilled nursing facility to which such paragraph applies.

(3) The amount payable under part A for post-hospital extended care services furnished an individual during any spell of illness in a skilled nursing facility to which paragraph (1) applies shall be reduced by a co-insurance amount equal to one eighth of the inpatient hospital deductible for each day before the 31st day on which he is furnished such services in such a facility during such spell (and the reduction under this paragraph shall be in lieu of any reduction under section 1395e(a)(3) of this title).

(4) For purposes of subsection (i) of this section, the determination of whether services furnished by or in an institution described in paragraph (1) constitute post-hospital extended care services shall be made in accordance with and subject to such conditions, limitations, and requirements as may be provided in regulations.

Institutional planning

(z) An overall plan and budget of a hospital, extended care facility, or home health agency shall be considered sufficient if it—

(1) provides for an annual operating budget which includes all anticipated income and expenses related to items which would, under generally accepted accounting principles, be considered income and expense items (except that nothing in this paragraph shall require that there be prepared, in connection with any budget, an item-by-item identification of the components of each type of anticipated expenditure or income);

(2) provides for a capital expenditures plan for at least a 3-year period (including the year to which the operating budget described in subparagraph (1) is applicable) which includes and identifies in detail the anticipated sources of financing for, and the objectives of, each anticipated expenditure in excess of \$100,000 related to the acquisition of land, the improvement of land, buildings, and equipment, and the replacement, modernization, and expansion of the buildings and equipment which would, under generally accepted accounting principles, be considered capital items;

(3) provides for review and updating at least annually; and

(4) is prepared, under the direction of the governing body of the institution or agency, by a committee consisting of repre-

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Part 86 of 10 New York Code of Rules and
Regulations adopted July 1, 1970: Reporting
and Rate Certification for Medical Facilities

PART 86

REPORTING AND RATE CERTIFICATION FOR MEDICAL FACILITIES

(Statutory authority: Public Health Law, §§ 2805 and 2807)

Sec.		Sec.	
86.1	Definition	86.16	Final rates
86.2	Medical facility rates; article IX-C corporations	86.17	Revisions in certified rates
86.3	Financial and statistical data required	86.18	Rates for services
86.4	Uniform system of accounting and reporting	86.19	Rates for medical facili- ties without adequate cost experience
86.5	Generally accepted accounting principles	86.20	Less expensive alternatives
86.6	Accountant's certification	86.21	Allowable costs
86.7	Certification by operator or officer	86.22	Recoveries of expense
86.8	Audits	86.23	Depreciation
86.9	Patient days	86.24	Interest
86.10	Effective period of reimburse- ment rates	86.25	Research
86.11	Computation of basic rate	86.26	Educational activities
86.12	Payment for referred ambulatory services	86.27	Compensation of owners
86.13	Groupings	86.28	Costs of related organizations
86.14	Ceilings on payments	86.29	Return on investment
86.15	Adjustments to basic computed rate	86.30	Temporary rental allowance; proprietary nursing homes
		86.31	Incentive allowance; pro- prietary nursing homes

Section 86.1 Definition. As used in this Part, the term medical facility shall be deemed to include all facilities covered by the term hospital as defined in article 28 of the Public Health Law.

86.2 Medical facility rates; article IX-C corporations. (a) Computation of rates of payment by article IX-C corporations to medical facilities shall be governed by the provisions of this Part.

(b) Each such corporation shall submit, for approval by the State Commissioner of Health, a proposed reimbursement formula not inconsistent with the rules set forth in this Part.

(c) Any such corporation or combination of corporations may, upon application to and approval of the State Commissioner of Health, use a different grouping of facilities for reimbursement computation purposes, provided such grouping assures incentive for the efficient operation of individual medical facilities equal to those under the groupings provided for in section 86.13.

(d) For rates of payment by such corporations, allowable costs may include, as determined by the State Commissioner of Health, a portion of the costs of a medical facility which represents a "community service" cost incurred in caring for medically indigent persons who are determined not to be eligible for the State medical assistance program.

(e) The State Commissioner of Health may not certify rate schedules for payments by such corporations unless they have submitted to the commissioner and received approval of a plan which:

- (1) establishes a procedure for monitoring the need for hospital admissions of its subscribers; and
- (2) establishes a procedure for the re-certification of a subscriber's continued hospital service needs.

86.3 Financial and statistical data required. (a) Each medical facility shall complete and file with the New York State Department of Health and/or its agent annual financial and statistical report forms supplied by the department and/or its agent. Medical facilities certified for Title XVIII (Medicare) must use the same fiscal year for Title XIX (Medicaid) and Title V (Children's Bureau programs) as is used for Title XVIII.

(b) Reports must be submitted to the department and/or its agent no later than 90 days following the close of the fiscal period of the medical facility.

(c) In the event a medical facility fails to file the required financial and statistical reports on or before the due date, the State Commissioner of Health may, for the subsequent rate period, certify an existing rate or a reduced rate as deemed to be appropriate. Such rate will be continued until the first day of the month following 30 days after receipt of the required report.

86.4 Uniform system of accounting and reporting. Medical facilities shall maintain their records in accordance with the appropriate uniform chart of accounts and definitions established by the State Commissioner of Health.

86.5 Generally accepted accounting principles. The completion of the financial and statistical report forms shall be in accordance with generally accepted accounting principles as applied to the medical facility unless the reporting instructions authorize specific variation in such principles.

86.6 Accountant's certification. The financial and statistical reports shall contain, as required by the State Commissioner of Health, a statement by an independent licensed or certified public accountant. The requirements of this section shall not apply to medical facilities operated by units of government of the State of New York.

86.7 Certification by operator or officer. The financial and statistical reports are to be certified by the operator or an officer of the medical facility.

86.8 Audits. (a) All fiscal and statistical records and reports are subject to audit.

(b) Subsequent to the filing of required fiscal and statistical reports, field audits will be conducted of the records of medical facilities, when appropriate, and in a time and manner to be determined by the State Department of Health. Where feasible, the department will enter into an agreement to use a combined audit (Medicare-Medicaid and other organizations and agencies having audit responsibilities) to satisfy the department's auditing needs.

86.9 Patient days. (a) A patient day is the unit of measure denoting lodging provided and services rendered to one inpatient between the census-taking hour on two successive days.

(b) In computing patient days, the day of admission will be counted but not the day of discharge. When a patient is admitted and discharged on the same day, this period is counted as one patient day.

(c) For reimbursement purposes, three newborn days are considered the equivalent of one adult or child day.

86.10 Effective period of reimbursement rates. Certification of reimbursement rates will be for a 12-month period from July 1 through June 30 of each subsequent year.

86.11 Computation of basic rate. (a) Basic rates will be computed on the basis of allowable fiscal and statistical data submitted by the medical facility for the fiscal year ended at least six months prior to the effective date of the rate. The computed rates will be all-inclusive rates taking into consideration total allowable costs and total inpatient days and visits.

(b) Reimbursement rates for emergency and clinic outpatient services will be computed on the basis of allowable costs and patient visits.

86.12 Payment for referred ambulatory services. Effective July 1, 1970, payments to hospitals for services to referred ambulatory patients will be on a fee-for-service basis in accordance with State fee schedules promulgated for the appropriate services.

86.13 Groupings. (a) For the purpose of establishing ceilings, medical facilities will be grouped as follows:

(1) Type of medical facility:

- (i) hospitals part of or affiliated with teaching centers or maintaining a substantial program of graduate education;
- (ii) general hospitals;
- (iii) special hospitals by type;
- (iv) nursing homes;
- (v) health related facilities;
- (vi) independent out-of-hospital health facilities.

(2) Geographic areas:

- (i) Western New York Hospital Service Region;
- (ii) Rochester Hospital Service Region;
- (iii) Central New York Hospital Service Region;
- (iv) Northeastern New York Hospital Service Region;
- (v) Long Island Hospital Service Region;
- (vi) Northern Metropolitan Hospital Service Region;
- (vii) New York City Hospital Service Region.

(3) Size of medical facility:

(i) For hospitals:

- (a) under 100 beds;
- (b) 100 - 199 beds;
- (c) 200 - 299 beds;
- (d) 300 - 499 beds;
- (e) over 500 beds.

(ii) For nursing homes:

- (a) under 40 beds;
- (b) 40 - 99 beds;
- (c) 100 - 199 beds;
- (d) 200 - 299 beds;
- (e) 300 and over.

(4) Sponsor:

- (i) voluntary hospitals;
- (ii) public hospitals;
- (iii) proprietary hospitals;
- (iv) voluntary nursing homes;
- (v) public nursing homes
- (vi) proprietary nursing homes

(b) Where one group contains an insufficient number of medical facilities needed to establish a reimbursable ceiling, such institutions will be considered as part of another comparable group or combined with comparable medical facilities without regard to geographic areas or size.

86.14 Ceilings on payments. (a) Ceilings as specified below for comparable groups of medical facilities will be established for the computation of reimbursement for service to inpatients. The ceilings will be considered prior to the addition of a factor to bring costs to projected expenditure levels during the effective period of the reimbursement rate.

(b) In computing the rate for inpatient routine services for hospitals, no amount shall be included that is in excess of 10 percent over the weighted average cost of routine inpatient services of all hospitals in the group. For the purpose of this paragraph, routine inpatient services shall not include capital costs, costs of schools of nursing, costs of interns and residents, and costs of ancillary services.

(c) In computing the rate for nursing homes, no amount shall be included that is in excess of that percentage determined on analysis of the total costs of the administrative, dietary and housekeeping services of all homes in a group which produces a ceiling to be applied to not more than 10 percent of the total nursing homes in the State. In no event shall the total allowable costs, excluding property costs, costs for therapy, costs of prescription drugs, return on net equity capital and incentive allowance, exceed 115 percent of the weighted average cost of all nursing homes in the group.

(d) For health related facilities which are affiliated with nursing homes, the maximum allowable costs which will be included in computing the reimbursement rate may be no more than 60 percent of the allowable per diem operational costs of the affiliated nursing home. For health related facilities which are not affiliated with another certified facility, the maximum rate may not exceed 60 percent of the weighted average per diem operational costs of nursing homes of similar size in the same geographic area. For this ceiling operating costs are defined as total costs less depreciation on real property, real estate taxes, interest on real property capital indebtedness, insurance on buildings, and real property rental payments.

86.15 Adjustments to basic computed rate. (a) Payment rates will be established on a prospective basis.

(b) To the allowable basic rate, computed in accordance with ceiling limitations, and prior to the addition of real property costs, return on net equity capital and incentive allowance, there will be added a factor to project allowable cost increases during the effective period of the reimbursement rate. Such factor will be determined as follows:

- (1) The elements of a medical facility's cost are to be weighted based on a sampling of data by the following categories:

Salaries and employee health and welfare expense to be computed based on a total of sub-weights.

Non-payroll administrative and general expense.

Non-payroll household and maintenance expense.

Non-payroll dietary expense.

Non-payroll professional care expense.

- (2) Each weight will be adjusted by the relevant price index, as follows:

Salaries and employee health and welfare:

New York State Department of Civil Service annual salary survey of hospitals.

Non-payroll administrative and general expense:

U.S. Department of Labor, Bureau of Labor Statistics, Wholesale Price Index, Office supplies; Consumer Price Index, insurance and finance.

Non-payroll household and property:

U.S. Department of Labor, Bureau of Labor Statistics, Consumer Price Index, laundry, soap, etc. Wholesale Price Index, office supplies, fuel and utilities.

Non-payroll dietary expense:

U.S. Department of Labor, Bureau of Labor Statistics, Wholesale Price Index, food.

Non-payroll professional care:

U.S. Department of Labor, Bureau of Labor Statistics, Consumer Price Index, adhesive bandages, Wholesale Price Index, office supplies, sanitary and health products, drugs and pharmaceutical supplies, x-ray equipment, electrotherapeutic equipment and tubes.

- (3) Geographic differentials may be established where appropriate.

86.16 Final rates. No retroactive adjustments will be made in rates certified pursuant to the foregoing rules. This does not preclude rate adjustments to correct errors in the determination of such rates.

86.17 Revisions in certified rates. (a) The State Commissioner of Health, at his discretion, may consider applications for prospective revisions of certified rates. In general, such applications will be approved if they result in continuing high quality care and improved operating efficiency with long term cost savings.

(b) Any request for prospective modification of a certified rate shall be accompanied by financial, statistical and program evidence sufficient to demonstrate a change in economic status and an expansion of services, improved quality of care, anticipated improved efficiency or projected long term cost savings.

(c) Any modified rate certified thereunder shall be effective on the first day of the month following 30 days after receipt of the request and justification.

(d) The State Commissioner of Health may in his discretion, certify a new rate, direct that a hearing be conducted to recommend whether a new rate should be certified, or disapprove the request for certification. In any event, the commissioner will notify the requesting party of his determination.

86.18 Rates for services. (a) The State Commissioner of Health shall, in certifying schedules for governmental payments to hospitals, identify any portion of rates provided for by such schedules which represent payments for routine inpatient services, inpatient ancillary services, allowable educational costs, and real property costs.

(b) Payment for newborns shall be made at one-third of the mother's rate.

(c) In addition to the foregoing identification of components included in payments for inpatient services, the schedules certified by the State Commissioner of Health shall provide for the following five categories of outpatient service:

- (1) emergency services;
- (2) clinic services;
- (3) home care services;
- (4) extension clinics;
- (5) independent out-of-hospital health facilities.

86.19 Rates for medical facilities without adequate cost experience. Rates certified for facilities where adequate fiscal and service data are not provided shall be determined on the basis of generally applicable factors, including but not limited to the following:

- (a) The usual and customary rates, for comparable services, in the geographic area.
- (b) Satisfactory cost projections.
- (c) Allowable actual expenditures.
- (d) An anticipated utilization of no less than the average for the geographic area.

86.20 Less expensive alternatives. Reimbursement for the cost of providing services shall be the lesser of the actual costs incurred or those costs which could reasonably be anticipated if such services had been provided by the operation of joint central services or use of facilities or services which could have served as effective alternatives or substitutes for the whole or any part of such service.

86.21 Allowable costs. (a) Allowable costs will generally include those costs directly related to patient care including but not limited to salaries, wages, employee fringe benefits, services, supplies, normal maintenance, minor building modification, property expense, interest and applicable taxes. Allowable costs will include a monetary value assigned to services provided by religious orders and for services rendered by an owner and operator of a facility. Allowable costs may not include costs incurred for open heart surgery in facilities not approved by the State Commissioner of Health for this service.

(b) Allowable costs in computing outpatient rates for payments by governmental agencies may include a loss incurred by a medical facility as a result of the failure of a person eligible for the medical assistance program to pay the deductible related to outpatient services.

86.22 Recoveries of expense. (a) Operating costs will be reduced by the cost of services and activities which are not properly chargeable to patient care. In the event that the State Commissioner of Health determines that it is not practical to establish the costs of such services and activities, the income derived therefrom may be substituted for costs. Examples of activities and services covered by this provision include:

- (1) drugs and supplies sold for use outside the medical facility;
- (2) telephone and telegraph services for which a charge is made;
- (3) discount on purchases;
- (4) living quarters rented to employees;
- (5) employee cafeterias;
- (6) meals provided to special nurses or patients' guests;
- (7) operation of parking facilities for community convenience;
- (8) lease of office and other space of concessionaires providing services not related to medical service;
- (9) tuitions and other payments for educational service, room and board and other services not directly related to medical service.

86.23 Depreciation. (a) Depreciation based on historical cost is recognized as a proper element of cost.

(b) For voluntary facilities, depreciation may be computed on either a straight line or appropriate accelerated method. Depreciation must be funded and used only for capital expenditures with approval as required or for the amortization of capital indebtedness.

(c) For public facilities, depreciation is to be computed on a straight line basis. Such depreciation is not required to be funded.

(d) For proprietary facilities, depreciation is to be computed on a straight line basis on plant and non-movable equipment. Depreciation may be computed on an appropriate accelerated basis under a declining balance not to exceed double declining or sum-of-the-years' digits methods on movable equipment.

86.24 Interest. (a) Necessary interest on both current and capital indebtedness is an allowable cost for all medical facilities.

(b) To be considered as an allowable cost, interest must be incurred to satisfy a financial need, and at a rate not in excess of what a prudent borrower would have had to pay in the money market at the time the loan was made. Also, the interest must be paid to a lender not related through control, ownership, affiliation or personal relationship to the borrower, except in instances where the prior approval of the Commissioner of Health has been obtained.

(c) Interest expense must be reduced by investment income with the exception of income from funded depreciation, qualified pension funds, or in instances where income from gifts or grants is restricted by donors. Interest on funds borrowed from a donor restricted fund or funded depreciation is an allowable expense.

86.25 Research. (a) All research costs shall be excluded from allowable costs in computing reimbursement rates.

(b) Research includes those studies and projects which have as their purpose the enlargement of general knowledge and understandings, are experimental in nature and hold no prospect of immediate benefit to the hospital or its patients.

86.26 Educational activities. The costs of educational activities less tuition and supporting grants will be included in the calculation of the basic rate provided such activities are directly related to patient care services.

86.27 Compensation of owners. (a) Reasonable compensation for owners or relatives of owners for services actually performed and required to be performed will be considered as an allowable cost. The amount to be allowed will be equal to the amount normally required to be paid for the same service provided by a non-related employee, as determined by the State Commissioner of Health.

(b) Any amount reported as compensation for services rendered by an owner or relative of an owner shall not be allowed in excess of the maximum allowance for full time services in carrying out his primary function.

86.28 Costs of related organizations. (a) Costs applicable to services, facilities and supplies furnished to the medical facility by organizations related to the provider by common ownership or control are includable in the computation of the basic rate at the cost to the related organization.

(b) If the provider has any interest whatsoever in the related organization, the final payment rate will include both the costs of the related organization in providing the services, facilities and supplies and a return on the equity capital of the related organization.

36.29 Return on investment. (a) In computing the allowable costs of a proprietary medical facility, there will be included an amount equal to 10 percent of the net equity capital of the institution.

(b) Equity capital is the net worth of the provider adjusted for those assets and liabilities which are not related to the provision of patient care. Equity capital consists of the provider's investment in plant, property and equipment, net of depreciation, and working capital for necessary and proper operation of patient care activities.

36.30 Temporary rental allowance; proprietary nursing homes. Within the rate of payment for proprietary nursing homes an amount may be included as an allowable cost which is equal to the amount included as "imputed rental" in the computation of the rate of payment currently in effect. This amount, if included, is in lieu of depreciation, interest on capital indebtedness and return on investment in real estate and non-movable equipment.

36.31 Incentive allowance; proprietary nursing homes. Within the rate of payment for proprietary nursing homes, an amount may be included as an allowable cost which is equal to a percentage established by the Commissioner to represent a sharing in the amount by which the total costs of administrative, dietary and housekeeping services of an individual facility are lower than the weighted average ceiling of the costs of these services for the group. In instances where the latest survey disclosed significant deficiencies in the operation of a facility, the incentive allowance will not be available.

4.

New York Public Health Law §§2807, 2803(1)(c),
2807 (as amended March 31, 1976) and 2808

§ 2806

PUBLIC HEALTH LAW

Art. 28

3. The commissioner or the health services administration of the city of New York, as the case may be, shall fix a time and place for the hearing. A copy of the charges, together with the notice of the time and place of the hearing, shall be served in person or mailed by registered mail to the hospital at least twenty-one days before the date fixed for the hearing. The hospital shall file with the department or with the health services administration of the city of New York, as the case may be, not less than eight days prior to the hearing, a written answer to the charges.

4. All orders or determinations hereunder shall be subject to review as provided in article seventy-eight of the civil practice law and rules.¹ Application for such review must be made within sixty days after service in person or by registered mail of a copy of the order or determination upon the applicant.

Added L.1965, c. 795, § 1; amended L.1969, c. 407, § 93, eff. May 9, 1969; L.1969, c. 419, eff. July 1, 1969.

¹ CPLR 7801 et seq.

Historical Note

Subd. 1 amended L.1969, c. 407, § 93, eff. May 9, 1969; L.1969, c. 419, eff. July 1, 1969. L.1969, c. 407, substituted references to officials or agencies to conform to terms used in New York City charter. L.1969, c. 419, without incorporating changes made by L.1969, c. 407, lettered clause (a) from existing provisions and added clause (b).

Subds. 2, 3 amended L.1969, c. 407, § 93, eff. May 9, 1969, which substituted references to officials or agencies to conform to terms used in New York City charter.

Effective date and implementation of L.1968, c. 862. See note under section 2805.

§ 2806-a. Repealed. L.1969, c. 532, § 5, eff. on 60th day after May 10, 1969

Historical Note

Section, which related to the approval, visitation and inspection of family-type proprietary facilities, was added L.1968, c. 562, § 7.

§ 2807. Payments for hospital and health-related service

1. No government agency and no corporation organized and operating in accordance with article nine-c of the insurance law¹ shall purchase, pay for or make reimbursement or grants-in-aid for any hospital or health-related service unless, at the time the service was provided, the hospital possessed a valid operating certificate authorizing such service.

Art. 28

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Art. 28

HOSPITALS

§ 2807

2. Payments for hospital service and health-related service made by government agencies or corporations organized and operating in accordance with article nine-c of the insurance law¹ shall be at rates approved by the state director of the budget in the case of government agencies and approved by the superintendent of insurance in the case of corporations organized and operating under article nine-c of the insurance law.¹ Notwithstanding the foregoing, rates of payment for hospital and health-related service made by government agencies, approved by the state director of the budget and in effect March thirty-first, nineteen hundred sixty-nine shall continue in effect for the period ending December thirty-first, nineteen hundred sixty-nine. Rates approved by the state director of the budget for the first time after March thirty-first, nineteen hundred sixty-nine shall continue in effect for the period ending December thirty-first, nineteen hundred sixty-nine.

3. Prior to the approval of such rates, the commissioner shall determine and certify to the superintendent of insurance and the state director of the budget that the proposed rate schedules for payments for hospital and health-related service are reasonably related to the costs of efficient production of such service. In making such certification, the commissioner shall take into consideration the elements of cost, geographical differentials in the elements of cost considered, economic factors in the area in which the hospital is located, the rate of increase or decrease of the economy in the area in which the hospital is located, costs of hospitals of comparable size, and the need for incentives to improve services and institute economies. The commissioner shall also take into consideration the economies and improvements in service to be anticipated from the operation of joint central service or use of facilities or services which may serve as alternatives or substitutes for the whole or any part of in-hospital service, including, but not limited to, obstetrical, pediatric, laboratory, training, radiology, pharmacy, laundry, purchasing, preadmission, nursing home, ambulatory or home care services. The commissioner shall exclude costs for research, those parts of the costs for educational salaries which the commissioner shall determine to be not directly related to hospital service, and allowances for costs which are not specifically identified.

Added L.1965, c. 795, § 1; amended L.1968, c. 862, § 8; L.1969, c. 184, § 20, eff. March 30, 1969; L.1969, c. 957, § 4, eff. May 26, 1969.

¹ Insurance Law § 250 et seq.

Historical Note

Subd. 1 amended L.1968, c. 862, § 8, eff. Sept. 1, 1968, which inserted reference to health-related service.

Subd. 2 amended L.1968, c. 862, § 8, eff. Sept. 1, 1968; L.1969, c. 184, § 20, eff. Mar. 30, 1969; L.1969, c. 957, § 4, eff. May 26, 1969. L.1968 included reference to health-related service. L.1969, c. 184, added sentences beginning "Notwithstanding the" and "Rates approved by." L.1969, c. 957, among other changes, substituted reference to Dec. 31, 1969 for reference to June 30, 1971 in two instances.

Subd. 3 amended L.1968, c. 862, § 8, eff. Sept. 1, 1968; L.1969, c. 957, § 4, eff. May 26, 1969. L.1968 included reference to health-related service. L.1969 in sentence beginning "Prior to the approval" substituted "effi-

cient production of" for "providing", a sentence beginning "In making" substituted "take into consideration * * * and institute economies" for "specify the elements of cost taken into consideration", and added sentences beginning "The commissioner shall also take" and "The commissioner shall exclude."

Effective date and implementation of L.1968, c. 862. See note under section 2805.

Legislative findings and purpose of L.1969, c. 957. See note under section 2803.

Separability of provisions of L. 1969, c. 184. See note under section 131 of the Social Services Law.

Notes of Decisions

Adequacy of rates 3
Constitutionality 1
Determination of rates 2
Payment at lower rate 4

1. Constitutionality

Subd. 2 of this section, insofar as it forbade full payment to hospitals of actual reasonable cost of inpatient services rendered to participants in New York medical assistance plan, was in conflict with Social Security Act, 42 U.S.C.A. § 301 et seq., and regulations thereunder and, as such, was unconstitutional as violative of supremacy clause. *Catholic Medical Center of Brooklyn & Queens, Inc., Division of St. Mary's Hospital v. Rockefeller*, C.A.N.Y.1970, 430 F.2d 1297.

2. Determination of rates

Action of state Commissioner of Health, in failing to follow the directive of subd. 3 of this section and then general regulatory guidelines prescribed for establishing rates properly chargeable by proprietary nursing home, amounted to assumption of powers in excess of those con-

ferred upon the Commissioner by law and consequently, the administrative action could not stand. *Sigety v. Ingraham*, 1970, 34 A.D.2d 316, 311 N.Y.S.2d 678.

Where the state Commissioner of Health failed to follow the directive of subd. 3 of this section and then general regulatory guidelines prescribed for establishing rates properly, chargeable by proprietary nursing home, the court would not assume power to determine proper rates and instead matter would be remanded for that purpose. *Id.*

Proprietary nursing home's right to establishment of proper rates for period from July 1 to December 31, 1969 could not be defeated by application of 1969 amendment to this section providing that rates of payment in effect on March 31, 1969, or approved after such date, shall continue in effect for remainder of the year, inasmuch as such amendment is properly limited in its application to such rates as have been lawfully determined and certified in first instance and may not be lawfully applied to validate or freeze rates which have not been so established. *Id.*

3. Adequacy

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§ 2808

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§ 2809

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council and the health systems agency concerned have had a reasonable time to submit their recommendations; and (b) the commissioner is satisfied as to the public need for the construction, at the time and place and under the circumstances proposed, provided however that, in the case of an application by a hospital established or operated by an organization defined in subdivision one of section four hundred eighty-two-a of the social services law, the needs of the members of the religious denomination concerned, for care or treatment in accordance with their religious or ethical convictions, shall be deemed to be public need.

[See main volume for text of 3 to 6]

As amended L.1971, c. 164, § 1; L.1976, c. 470, §§ 4, 5.

1976 Amendment. Subd. 1. L.1976, c. 470, § 4, eff. June 20, 1976, in sentence beginning "Thereafter the department" substituted "health systems agency" for "regional hospital planning council."

Subd. 2. L.1976, c. 470, § 5, eff. June 20, 1976, in clause (a), substituted "health systems agency" for "regional hospital planning councils."

1971 Amendment. Subd. 2 amended L.1971, c. 164, eff. April 21, 1971. L. 1971, in clause (a), substituted "public health council" for "board of social welfare" and "the provisions of this article" for "section thirty-five of the social welfare law", and inserted "state hospital review and planning"; and, in clause (b), substituted "social services law" for "social welfare law."

1. Regulations

Even assuming that Department of Health could validly prescribe construction standards for nursing homes pursuant to legislative delegation of authority under provision of this article, regulations adopted by Department for that purpose were arbitrary and unreasonable where such regulations were so vague, confusing and meaningless that they failed to inform parties subject to their effect of what was expected of them and unfairly placed them at mercy of whatever unannounced interpretation then happened to be in favor within Department. *Levine v. Whalen*, 1976. 50 A.D.2d 503, 378 N.Y.S.2d 800.

§ 2803. Commissioner and council; powers and duties

1. (a) The commissioner shall have the power to inquire into the operation of hospitals and home health agencies and to conduct periodic inspections of facilities with respect to the fitness and adequacy of the premises, equipment, personnel, rules and by-laws, standards of medical care, hospital service, including health-related service, home health service, system of accounts, records, and the adequacy of financial resources and sources of future revenues. The commissioner or persons designated by him shall each year conduct two or more inspections of each residential health care facility, at least one of which shall be unannounced, to determine the adequacy of care being rendered. Any employee of the department who gives or causes to be given advance notice of such unannounced inspection to any unauthorized person shall, in addition to any other penalty provided by law, be suspended by the commissioner from all duties without pay for at least five days or for such greater period of time as the commissioner shall determine. Any such suspension shall be made by the commissioner in accordance with all other applicable provisions of law.

(b) The purpose of such inspections shall be to determine compliance by residential health care facilities with statutes, and with regulations promulgated under the provisions of those statutes, governing minimum standards of construction, quality and adequacy of care, rights of patients, rates of payment and reimbursement. At least one such inspection each year shall include, but shall not be limited to, full on-site examination and audit of the medical, nursing care, dietary, social services and financial records of the facility. The on-site audits of financial records shall encompass the immediately preceding complete fiscal year of the residential health care facility, and shall not be conducted in any instance in which an audit of such fiscal year shall already have been completed as part of a previous inspection.

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(c) The commissioner shall promulgate and publish uniform cri-
teria for the evaluation of residential health care facilities with respect
to their compliance with the standards set forth in this section, as in-
dicated by the results of the inspections conducted pursuant to the
provisions of this section. Such criteria shall include a detailed listing
of the types, and degree of severity or unacceptability, of deficiencies
which inspections might indicate, and shall also indicate areas of care
and performance in which residential health care facilities notably and
significantly exceed required minimum standards. In promulgating
such criteria, the commissioner shall devise a system of rating resi-
dential health care facilities in accordance with the deficiencies and
areas of significantly high care and performance which the reports
of inspection shall have indicated. Such system shall include no less
than five specific rating categories. The rating assigned to each resi-
dential health care facility on the basis of its immediately prior
inspection shall be deemed a part of the results and findings of that
inspection, and shall be required by the commissioner to be posted con-
spicuously within the residential health care facility to which it ap-
plies. A facility may appeal the assignment of a particular rating to
the commissioner within twenty days after notice of its assignment.
The results and findings of any prior inspections, and any penalties
thereby assessed, which have not been previously appealed and over-
ruled, shall not be subject to review.

(d) Notwithstanding any inconsistent provision of law, the commis-
sioner or his designee shall, not later than July first, nineteen hundred
seventy-six, determine the necessity and appropriateness of care and
services provided by hospitals to individual patients eligible for medical
assistance pursuant to title eleven of article five of the social services
law. In making such determinations the commissioner may utilize the
services of department personnel or other authorized representatives.
The hospitals shall provide such information, facilities and services as
may be required by the commissioner to make such determinations.
The commissioner, in implementing this paragraph, shall adopt necessary
rules and regulations including but not limited to those for determining
the necessity of admission, controlling the length of stay, the provision
of surgery and other services, and the methods and procedures for
making such determinations. The commissioner shall certify to the so-
cial services officials responsible for making payments for authorized
hospital services that specified items of care and services for specified
individuals are inappropriate or unnecessary and are not authorized
for payment under the medical assistance program.

(e) Notwithstanding any inconsistent provision of law, the commis-
sioner or his designee shall, not later than July first, nineteen hundred
seventy-six, determine on an individual patient basis whether identifi-
able periods of in-patient care in a general hospital are required beyond
the maximum length of stay established pursuant to section three
hundred sixty-five-a of the social services law, and whether deferral of
surgical procedures specified by such commissioner in accordance with
paragraph (c) of subdivision five of such section may jeopardize life
or essential function, or cause severe pain. In making such deter-
minations the commissioner may utilize the services of department
personnel or other authorized representatives. The hospitals shall
provide such information, facilities and services as may be required by
the commissioner to make such determinations. The commissioner, in
implementing this paragraph, shall adopt necessary rules and regulations
including but not limited to the methods and procedures for making such
determinations and the utilization of any department staff or other
authorized representatives located at such hospital in performing other
functions relating to assuring that public funds for medical assistance
are utilized exclusively to provide items of care and services in amount,
duration and scope specifically authorized under the medical assistance

2. The council, by a majority vote of its members, shall accept and amend rules and regulations, subject to the approval of the commissioner, to effectuate the provisions and purposes of this article, including, but not limited to (a) the establishment of requirements for a uniform statewide system of reports and audits relating to the quality of medical and physical care provided, hospital utilization and costs in accordance with section twenty-eight hundred three-b, (b) establishment by the department of schedules of rates, payments, reimbursements, grants and other charges for hospital, health-related services and home health services as provided in section two thousand eight hundred seven (c) standards and procedures relating to hospital operating certificates and home health certificates of approval, provided however, that the council shall establish minimum acceptable standards and procedures equal to the standards and procedures which federal law and regulation require for hospitals to qualify as providers pursuant to titles XVIII and XIX of the federal social security act.¹ The existing state standards and procedures in effect on the date that this section becomes effective shall be deemed to constitute maximum standards and procedures for purposes of limiting medical assistance reimbursement pursuant to the social services law. Such standards and procedures may thereafter be changed or added to by the council only upon the recommendation of the commissioner. For the purposes of ensuring that the health and safety of the residents of hospitals are not endangered, the council may promulgate changes in the minimum acceptable standards and procedures referred to herein upon recommendation of the commissioner. For the purposes of orderly implementation of this subdivision, the commissioner of health may grant waivers to maximum reimbursable standards to expire no later than March thirty-first, nineteen hundred seventy-eight and (d) the establishment of a system of accounts and cost findings to be used by hospitals, including a classification of such hospitals and the prescription of a system of accounts and cost finding for each class in accordance with section twenty-eight hundred three-b. The commissioner may propose rules and regulations and amendments thereto for consideration by the council.

[See main volume for text of 4 and 5]

6. The council, by a majority vote of its members and subject to the approval of the commissioner, shall adopt rules and regulations to establish (a) a system of penalties of up to one thousand dollars per day for continuing violations of rules and regulations promulgated pursuant to article twenty-eight of this chapter¹ and pertaining to patient care by residential health care facilities, specifying the violations and the amount of the penalty to be assessed in connection with each such violation, and (b) a system by which the rate of payment approved for a residential health care facility pursuant to section twenty-eight hundred seven of this chapter and certified to the department of social services for purposes of reimbursement in the medical assistance program, is reduced in sufficient amount to collect such penalties. Any reduction of rate to collect penalties shall be limited to five percent of the otherwise established per diem rate or that portion of the per diem rate which represents the owner's return on equity, as defined by regulation, whichever is less.

1975 Amendment
1975, c. 653, § 1,
provided that each

to the social services officials authorized hospital services that specified individuals are not medical assistance program.

its members, shall adopt and the approval of the commissioner purposes of this article, in fulfillment of requirements for a audits relating to the quality hospital utilization and costs in hundred three-b, (b) establishment of rates, payments, reimbursement, health-related services and two thousand eight hundred relating to hospital operating cost of approval, provided however, minimum acceptable standards and procedures which federal law qualify as providers pursuant to social security act.¹ The effect on the date that this second to constitute maximum standards limiting medical assistance services law. Such standards and or added to by the council only commissioner. For the purposes of the residents of hospitals are to be referred to herein upon recommendation of the commissioner of health may grant standards to expire no later than seventy-eight and (d) the standard cost findings to be used by of such hospitals and the predicted cost finding for each class in hundred three-b. The commissions and amendments thereto for

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of its members and subject to the adopt rules and regulations to of up to one thousand dollars per and regulations promulgated pursuant to chapter 1 and pertaining to patient services, specifying the violations and assessed in connection with each such the rate of payment approved for pursuant to section twenty-eight hundred to the department of social in the medical assistance program to collect such penalties. Any shall be limited to five percent of rate or that portion of the per diem return on equity, as defined by regu-

7. The commissioner shall have the power to assess penalties in accordance with the system of penalties adopted pursuant to subdivision six of this section pursuant to a hearing conducted in accordance with section twelve-a of this chapter. No penalty shall be assessed for any violation unless the facility has received at least thirty days written notice of the existence of the violation, the amount of the penalty for which it may become liable and the steps which must be taken to rectify the violation. If the facility fails to rectify the violation within said thirty day period, it shall thereafter be liable for such penalty. Any such penalties shall be subject to release and compromise by the commissioner in the same manner as a penalty provided by subdivision one of section twelve of this chapter. Any penalty shall be subject to recovery in the same manner as a penalty provided by subdivision one of section twelve of this chapter or pursuant to the system for reduction of the rate of payment to the facility adopted pursuant to clause (c) of subdivision six of this section. Such penalty shall be additional and cumulative to all other penalties or remedies existing for violations of rules and regulations promulgated pursuant to article twenty-eight of this chapter.

As amended L.1972, c. 918, § 4; L.1974, c. 956, § 2; L.1975, c. 649, §§ 4, 8; L.1975, c. 653, § 1; L.1975, c. 660, § 1; L.1976, c. 76, § 8; L.1976, c. 470, § 6; L.1976, c. 940, §§ 3, 4.

142 U.S.C.A. § 1395 et seq. and § 1396 et seq.

1976 Amendments. Subd. 1, par. (d). L.1976, c. 940, § 3, eff. July 27, 1976, among other changes, in sentence beginning "Notwithstanding" inserted "or his designee" and "eligible for medical assistance pursuant to title eleven of article five of the social services law" and struck out reference to home health agencies, and in sentence beginning "The commissioner shall", substituted "making payments for authorized hospital services that specified items of care and services for specified individuals are inappropriate or unnecessary and are not authorized for payment under the medical assistance program" for "authorized hospital or health related services that payment for inappropriate or unnecessary care shall be withheld."

L.1976, c. 76, § 8, eff. Mar. 30, 1976, retroactive to Jan. 1, 1976, added par. (d).

Subd. 1, par. (e). L.1976, c. 940, § 4, eff. July 27, 1976, added par. (e).

Subd. 2. L.1976, c. 76, § 8, eff. Mar. 30, 1976, retroactive to Jan. 1, 1976, in clause (c), added proviso relating to the federal social security act, sentences beginning "The existing state", "Such standards", and "For the purposes of insuring", and authorized the commissioner to grant waivers expiring no later than Mar. 31, 1978.

Subd. 3. L.1976, c. 470, § 6, eff. June 29, 1976, substituted "health systems agency" for "regional hospital council."

1975 Amendments. Subd. 1. L.1975, c. 653, § 1, eff. Sept. 1, 1975, provided that each year the commis-

sioner must conduct two or more inspections, one of which must be unannounced, and any employee who gives advance notice of such unannounced inspection shall be suspended by the commissioner without pay for at least 5 days.

L.1975, c. 649, § 4, eff. Sept. 1, 1975, designated existing provisions as par. a and added pars. b and c.

Subds. 6, 7. L.1975, c. 660, § 1, eff. Sept. 1, 1975, added subds. 6, 7.

Subd. 7. L.1975, c. 649, § 3, eff. Sept. 1, 1975, substituted "a hearing conducted in accordance with" for "the procedures set forth in."

1974 Amendment. Subd. 2. L.1974, c. 956, § 2, eff. June 13, 1974, inserted references to section 2803-b in clauses (a) and (d).

1972 Amendment. Subd. 1. L.1972, c. 918, § 4, eff. Apr. 1, 1973, inserted "and home health agencies."

Subd. 2. L.1972, c. 918, § 4, eff. Apr. 1, 1973, in clause (b) inserted "home health services" and in clause (c) inserted "and home health certificates of approval."

Application of L.1972, c. 918. See note under section 2801.

Home Care Licenses or Certificates Issued Prior to April 1, 1973. See note under section 2804-a.

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PUBLIC HEALTH LAW

1976, 50 A.D.2d 503, 378 N.Y.S.2d
800.

5. Proof of failure of compliance

5. Proof of failure of compliance

Once issued, nursing home-operating certificate may be revoked only on proof of failure to comply with provisions of this section respecting hospitals and related services or rules and regulations promulgated thereunder. *Levine v. Whalen*, 1976, 50 A.D.2d 503, 378 N.Y.S.2d 800.

7. A home health agency certificate of approval may be revoked, suspended, limited or annulled by the commissioner on proof that the home health agency has failed to comply with the provisions of this article or rules and regulations promulgated thereunder.

2. No home health agency certificate of approval shall be revoked, suspended, limited or annulled without a hearing. However, a certificate may be temporarily suspended or limited without a hearing for a period not in excess of thirty days upon written notice to the home health agency following a finding by the department that the public health or safety is in imminent danger.

3. The commissioner shall fix a time and place for the hearing. A copy of the charges, together with the notice of the time and place of the hearing, shall be served in person or mailed by registered mail to the home health agency at least twenty-one days before the date fixed for the hearing. The home health agency shall file with the department not less than eight days prior to the hearing, a written answer to the charges.

4. All orders or determinations hereunder shall be subject to review as provided in article seventy-eight of the civil practice law and rules. Application for such review must be made within sixty days after service in person or by registered mail of a copy of the order or determination upon the applicant.

Added L.1972, c. 918, § 7.

¹ Section enacted without catchline which has been supplied by editor.

Effective Date. Section 15 of L. 1972, c. 918, provided that this section is effective Apr. 1, 1973.

Application of L.1972, c. 918. See note under section 2801.

§ 2807. Payments for hospital and health-related service

1. No government agency and no corporation organized and operating in accordance with article nine-c of the insurance law and no health maintenance organization organized and operating in accordance with article forty-four of this chapter, shall purchase, pay for or make reimbursement or grants-in-aid for any hospital or health-related service, including home health service, unless, at the time the service was provided, the hospital possessed a valid operating certificate authorizing such service or in the case of a home health agency a valid certificate of approval. No government agency shall purchase, pay for or make reimbursement or grants-in-aid for any hospital or health related service, including home health services that have been determined by the commissioner of health to be unauthorized for payment under the medical assistance program pursuant to section twenty-eight hundred three of this chapter.

2. (a) Payments for hospital service and health-related service, including home health service, made by government agencies or corpora-

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(b) Notwithstanding the expiration of the period of payment authorized by the Government agency, the contract shall continue in effect until the hundred sixty-fourth day after the date for the first payment, and shall continue in effect until the hundred and ninety-ninth day after the date for the first payment.

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(d) For the seventy-five state director. Nothing contained as the result of hundred three or :

(e) During seventy-six, or seven, the commission the budget rate out regard to the commissioner's provisions of hundred three which rates shall this paragraph tion twenty-e-

2-a. Prior to the effective date of the order, the following services shall be provided to the community: (1) emergency services; (2) mental health services; (3) substance abuse services; (4) domestic violence services; (5) child welfare services; (6) adult protective services; (7) elder services; (8) family violence services; (9) juvenile justice services; (10) community development services; (11) economic development services; (12) health services; (13) housing services; (14) public safety services; (15) social services; (16) transportation services; (17) utility services; (18) waste management services; (19) water services; (20) other services as may be determined by the community development board.

2-b. There is
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tions organized and operating in accordance with article nine-c of the in-
surance law or organizations operating in accordance with the pro-
visions of article forty-four of this chapter shall be at rates approved
by the state director of the budget in the case of government agencies
and approved by the superintendent of insurance in the case of corpo-
rations organized and operating under article nine-c of the insurance
law, and approved by the commissioner in the case of plans, organized
and operating under the provisions of article forty-four of this chapter,
under which such payments are made by agencies other than govern-
ment agencies or corporations organized and operating in accordance
with article nine-c of the insurance law.

(b) Notwithstanding the provisions of paragraph (a) above, rates
of payment for hospital and health-related service made by gov-
ernment agencies, approved by the state director of the budget
and in effect March thirty-first, nineteen hundred sixty-nine shall con-
tinue in effect for the period ending December thirty-first, nineteen
hundred sixty-nine. Rates approved by the state director of the budget
for the first time after March thirty-first, nineteen hundred sixty-nine
shall continue in effect for the period ending December thirty-first
nineteen hundred sixty-nine.

(c) Notwithstanding any inconsistent provision of law, rates of pay-
ment for government agencies for general hospital out-patient and
emergency services, and for treatment or diagnostic center services
during the period January first, nineteen hundred seventy-six through
March thirty-first, nineteen hundred seventy-seven shall be at no more
than one hundred percent of the approved nineteen hundred seventy-
five rates for such services.

(d) For the purpose of this subdivision approved nineteen hundred
seventy-five rates shall mean those rates originally approved by the
state director of the budget, together with any approved rate revisions.
Nothing contained herein shall be deemed to preclude further revisions
as the result of audits conducted pursuant to section twenty-eight hun-
dred three of this chapter.

(e) During the period beginning January first, nineteen hundred
seventy-six, and ending March thirty-first, nineteen hundred seventy-
seven, the commissioner may determine and certify to the director of
the budget rates of payment for residential health care facilities with-
out regard to the provisions of subdivision three of this section. The
commissioner is directed to formulate such rates in accordance with the
provisions of paragraph c of subdivision one of section twenty-eight
hundred three and section twenty-eight hundred eight of this chapter
which rates shall be effective for the period hereinbefore specified in
this paragraph notwithstanding any inconsistent provision of such sec-
tion twenty-eight hundred eight.

2-a. Prior to the approval of rates of payment for hospitals, ex-
clusive of residential health care facilities and outpatient and emer-
gency services and treatment and diagnostic centers, made by govern-
ment agencies, the state director of the budget shall take into con-
sideration economic conditions within the state which affect the eco-
nomic resources available to meet the cost of government-funded medi-
cal services. If economic conditions are determined by such director
to be likely to have a severe adverse effect on the ability of the state
government to make sufficient resources available to purchase medical
care at the proposed rates, the director shall return the proposed rates
to the commissioner, and direct him to revise the rates to comply with
the director's finding. Such revised rates shall not be certified to the
superintendent of insurance for corporations organized and operating in
accordance with article nine-C of the insurance law which corporations
shall continue to be subject to the rates of payment otherwise estab-
lished pursuant to law.

2-b. There shall be a hospital rate review board in the department
consisting of the comptroller, the director of the budget, the commis-

sioner of health who shall serve as chairman, one member appointed by the governor upon nomination by the temporary president of the senate, and one member appointed by the governor upon nomination by the speaker of the assembly. The members appointed by the governor upon the nomination of the temporary president of the senate and the speaker shall receive reimbursement for actual and necessary expenses. The board shall hear appeals from the rate determinations made pursuant to subdivision two-a of this section. The board shall uphold the decision of the director of the budget unless the appellant can establish that: the rate of payment allowed is inadequate to provide care equal to that required to meet minimum acceptable standards and procedures required by section twenty-eight hundred three of this article; and that the costs of providing such care are reasonably related to the efficient production of medical care and services. Whenever the board shall find that the rate of payment is insufficient to provide for the efficient production of medical care and services equal to that required to meet the minimum acceptable standards and procedures required by section twenty-eight hundred three, it shall direct the commissioner of health to certify a revised rate of payment sufficient to meet such standards.

3. Prior to the approval of such rates, the commissioner shall determine, and in the case of approvals by the superintendent of insurance or the state director of the budget certify to such officials, that the proposed rate schedules for payments for hospital and health-related service, including home health service, are reasonably related to the costs of efficient production of such service. In making such certification, the commissioner shall take into consideration the elements of cost, geographical differentials in the elements of cost considered, economic factors in the area in which the hospital or agency is located, the rate of increase or decrease of the economy in the area in which the hospital or agency is located, costs of hospitals or agencies of comparable size, and the need for incentives to improve services and institute economies. The commissioner shall also take into consideration the economies and improvements in service to be anticipated from the operation of joint central service or use of facilities or services which may serve as alternatives or substitutes for the whole or any part of in-hospital service, including, but not limited to, obstetrical, pediatric, laboratory, training, radiology, pharmacy, laundry, purchasing, preadmission, nursing home, ambulatory or home care services. The commissioner shall exclude costs for research, those parts of the costs for educational salaries which the commissioner shall determine to be not directly related to hospital service or home health service, and allowances for costs which are not specifically identified.

4. [See, also, subds. 4, set out below] The commissioner shall notify each hospital and health-related service of its approved rate at least sixty days prior to the fiscal year for which the rate is to become effective.

4. [See, also, subds. 4, set out above and below] The commissioner shall not certify to the superintendent of insurance and the state director of the budget that proposed rate schedules for a hospital are reasonably related to the costs of efficient production, as required in subdivision three of this section, unless such hospital is in full compliance with the reporting requirements of this article.

4. [See, also, subds. 4, set out above and below] The commissioner of health shall include in costs allocated to in-patient services the net loss incurred by a voluntary hospital as defined by the commissioner in rendering ambulatory and emergency services, when such net loss is adjusted by any operating surplus attributable to all other hospital services, and payments for in-patient hospital services by governmental agencies, including federal agencies, to the extent authorized by federal law and regulation, and corporations organized and operating in accordance with article IX-C of the insurance law shall

include a proportion of in-patient services from the difference reasonably related to out-patient services of revised rates the power of determining the net loss of net loss determinations latory and

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1976 Am 1976, c. 1 substitution of program necessary or in

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Subds. 12, eff. Jan. 1, 2-b.

Subd. 2 July 27, of app inserted

one member appointed by any president of the senate, upon nomination by the senate and the speaker, and necessary expenses. The board shall uphold the standards and procedures of the hospital or agency which the appellant can establish to provide care equal to that required by the commissioner of health services. Whenever the board determines not to have been reasonably related to the provision of ambulatory and emergency services.

the commissioner shall determine the superintendent of in-patient services the net loss of in-patient services bears to the total in-patient services. Net loss from the rendering of ambulatory and emergency services shall mean the difference if any, between the direct and indirect costs which are reasonably related to audited costs of efficient production of preadmission, out-patient, ambulatory, post-discharge and emergency services (exclusive of referred ambulatory, employee or courtesy services), and the audited revenues received for such services. The commissioner shall have the power in determining such loss to audit such revenues with respect to determining whether revenue collection and patient charges are reasonably related to the efficient production of revenues and the minimization of net loss, and to disallow any portion of such loss which such audit determines not to have been reasonably related to the provision of ambulatory and emergency services.

The commissioner shall notify its approved rate at least six days prior to the beginning of an established rate period for which the rate is to become effective.

and below] The commissioner of in-patient services the net loss of in-patient services bears to the total in-patient services. Net loss from the rendering of ambulatory and emergency services shall mean the difference if any, between the direct and indirect costs which are reasonably related to audited costs of efficient production of preadmission, out-patient, ambulatory, post-discharge and emergency services (exclusive of referred ambulatory, employee or courtesy services), and the audited revenues received for such services. The commissioner shall have the power in determining such loss to audit such revenues with respect to determining whether revenue collection and patient charges are reasonably related to the efficient production of revenues and the minimization of net loss, and to disallow any portion of such loss which such audit determines not to have been reasonably related to the provision of ambulatory and emergency services.

include a share of such adjusted net loss which share shall bear the same proportion to the total net loss that the agencies' or corporations' share of in-patient services bears to the total in-patient services. Net loss from the rendering of ambulatory and emergency services shall mean the difference if any, between the direct and indirect costs which are reasonably related to audited costs of efficient production of preadmission, out-patient, ambulatory, post-discharge and emergency services (exclusive of referred ambulatory, employee or courtesy services), and the audited revenues received for such services. The commissioner shall have the power in determining such loss to audit such revenues with respect to determining whether revenue collection and patient charges are reasonably related to the efficient production of revenues and the minimization of net loss, and to disallow any portion of such loss which such audit determines not to have been reasonably related to the provision of ambulatory and emergency services.

4. [See, also, subds. 4, set out above] The commissioner shall notify each hospital and health-related service of its approved rate at least six days prior to the beginning of an established rate period for which the rate is to become effective.

5. Any payments made under the authority of this section shall not preclude payments under any other section of law, notwithstanding any provision of law to the contrary.

As amended L.1972, c. 918, § 8; L.1974, c. 682, § 1; L.1974, c. 956, § 4; L.1974, c. 1061, § 2; L.1974, c. 1062, §§ 1, 2; L.1976, c. 76, §§ 10-13; L.1976, c. 938, §§ 4-6; L.1976, c. 940, § 5.

1976 Amendments. Subd. 1. L. 1976, c. 940, § 5, eff. July 27, 1976, substituted "unauthorized for payment under the medical assistance program pursuant to" for "unnecessary or inappropriate under."

L.1976, c. 938, § 4, eff. July 27, 1976, provided that no health maintenance organization organized and operating in accordance with article 44 shall pay for hospital and health related services, and substituted "chapter" for "title."

L.1976, c. 76, § 10, eff. on the 45th day next succeeding Mar. 30, 1976, added sentence beginning "No government agency shall purchase."

Subd. 2. L.1976, c. 938, § 5, eff. July 27, 1976, provided for approval by the commissioner in the case of plans organized and operating under article 44, under which payments are made by agencies other than government agencies or corporations organized and operating in accordance with article 9-c of the Insurance Law.

L.1976, c. 76, § 11, eff. Mar. 30, 1976, retroactive to Jan. 1, 1976, designated existing provisions as pars. (a) and (b), and added pars. (c) to (e).

Subds. 2-a, 2-b. L.1976, c. 76, § 12, eff. Mar. 30, 1976, retroactive to Jan. 1, 1976, added subds. 2-a and 2-b.

Subd. 3. L.1976, c. 938, § 6, eff. July 27, 1976, substituted "in the case of approvals" for "certify to" and inserted "certify to such officials."

Subd. 4, set out fourth. L.1976, c. 76, § 13, eff. Mar. 30, 1976, added subd. 4.

1974 Amendments. Subd. 4, set out third. L.1974, c. 1061, § 2, eff. Sept. 1, 1974, added subd. 4.

Subd. 4, set out third. L.1974, c. 1062, § 1, eff. Sept. 1, 1974, in sentence beginning "The commissioner of health" inserted "as defined by the commissioner", "when such net loss is adjusted by any operating surplus attributable to all other hospital services" and "adjusted" preceding "net," in sentence beginning "Net loss" inserted "from the rendering of ambulatory and emergency services", and added sentence beginning "The commissioner shall have the power."

Subd. 4, set out second. L.1974, c. 956, § 4, eff. June 13, 1974, added subd. 4.

Subd. 4, set out first. L.1974, c. 682, § 1, eff. Sept. 1, 1974, added subd. 4.

Subd. 5. L.1974, c. 1062, § 2, eff. Sept. 1, 1974, added subd. 5.

1972 Amendment. Subd. 1. L.1972, c. 918, § 8, eff. Apr. 1, 1973, inserted "home health service" and added "or in the case of a home health agency a valid certificate of approval."

Subd. 2. L.1972, c. 918, § 8, eff. Apr. 1, 1973, inserted "including home health service."

Subd. 3. L.1972, c. 918, § 8, eff. Apr. 1, 1973, inserted "including home health service."

Termination of L.1976, c. 76. L. 1976, c. 76, § 18, provided in part that subds. 2-a, 2-b and 4, set out

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PUBLIC HEALTH LAW

Note 2

fourth, "shall be and remain effective only to and including Mar. 31, 1977 and shall be thereafter effective only in respect to any act done on or before such date or action or proceeding arising out of such act."

Suspension of L.1974, c. 682. L. 1976, c. 76, § 16, eff. Mar. 30, 1976, provided that subd. 4, set out first, shall, for all purposes, be deemed to have been without any force and effect from and after Nov. 1, 1975.

L.1976, c. 76, § 18, provided in part that section 16 of the Act suspending effectiveness of subd. 4, set out first, "shall be and remain effective only to and including March thirty-first, nineteen hundred seventy-seven and shall be thereafter effective only in respect to any act done on or before such date or action or proceeding arising out of such act."

Legislative Findings. L.1974, c. 1061, § 1, eff. Sept. 1, 1974, provided: "The provision of ambulatory and emergency services is an integral part of the operation of a voluntary hospital and a cost of business which should be shared by all payors for use of the hospital. Voluntary hospitals render ambulatory services to the medically indigent, which provide less costly alternatives to in-patient care, reducing the cost of hospital services for all patients, and further render emergency services, which under the law of this State must be provided regardless of the patient's ability to pay. The historical policy of reimbursement in this State has recognized that losses attributable to the costs of such services must be shared among all who use the services of a voluntary hospital, and failure to share such losses equitably contravenes the efficient production of hospital services, and threatens the continuance of ambulatory care by the voluntary hospitals of this State."

Application of L.1972, c. 918. See note under section 2801.

Home Care Licenses or Certificates Issued Prior to April 1, 1973. See note under section 2804-a.

Supplementary Index to Notes

Adjustments for overpayments 10
Efficient production cost basis 5
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Reimbursement of expenses 6
Review 9

2. Determination of rates

Sigety v. Ingraham, 34 A.D.2d 316, 311 N.Y.S.2d 678, main volume, re-

versed on other grounds 29 N.Y.2d 110, 324 N.Y.S.2d 10, 272 N.E.2d 524.

Commissioner of Health could set maximum reimbursement rate for nursing home services rendered to publicly assisted patients and state was not required to reimburse operator of nursing home whose costs were in excess of ceiling placed on costs by Commissioner. *Sigety v. Ingraham*, 1971, 29 N.Y.2d 110, 324 N.Y.S.2d 10, 272 N.E.2d 524.

Determination of state Commissioner of Health in limiting Medicaid reimbursement for nursing home services rendered to publicly assisted patients is not to be disturbed if it has a reasonable basis and is not arbitrary or capricious. *Id.*

State Commissioner of Health need only reimburse nursing facilities, with respect to Medicaid, at a rate that is reasonably related to the costs of the services performed and need not reimburse for actual costs. *Broadacres Skilled Nursing Facility v. Ingraham*, 1976, 51 A.D.2d 243, 381 N.Y.S.2d 131.

Regulation of Commissioner of Health whereby, if a specific group of facilities contains too few institutions to allow the calculation of a meaningful Medicaid reimbursement rate, institutions are allowed to be grouped with others similarly situated, is valid and not in conflict with statutory requirement that reimbursement rates be reasonably related to costs. *Id.*

State Health Commissioner, acting under mandate of subd. 3 of this section providing that rates be "reasonably related to the cost of efficient production of such service," properly considered property cost factor of nursing home's new owner in fixing the Medicaid reimbursement rate. *Sands Point Nursing Home v. Ingraham*, 1975, 48 A.D.2d 897, 370 N.Y.S.2d 14.

Determination of Commissioner of Health and Superintendent of Insurance that hospital not be given increases in reimbursement rates paid by Associated Hospital Service of New York for years 1970 and 1971 was not arbitrary or capricious, but would be modified to extent of including in recomputation of 1970 non-operating costs the cost of cardiac intensive care unit. *Presbyterian Hospital in City of New York v. Ingraham*, 1975, 48 A.D.2d 491, 369 N.Y.S.2d 738.

Actions of Commissioner of Health in including community service factor in formula for determining reimbursement rates to be paid hospital

by Associated New York was praiseworthy. *Id.*

Under regular hospital is entitled to reimbursement in accord with its rate, regardless of the fact that voluntary hospital failed to pay its rate, retroactive reimbursement of department reduced actual reimbursement from level of its rate. *St. Peter v. Ingraham*, 1975, 588, 381 N.Y.S.2d 181, 381 N.Y.S.2d 181, 381 N.Y.S.2d 181, 381 N.Y.S.2d 181.

Decision of Health and Insurance Commission approving rate, which would have caused hospital to pay more than it had not closed, was not retroactive on rates 1974 rates were insurer as offset to hospital and was not retroactive. *St. Peter v. Ingraham*, 1975, 588, 381 N.Y.S.2d 181, 381 N.Y.S.2d 181, 381 N.Y.S.2d 181, 381 N.Y.S.2d 181.

Regulation of Commissioner of Health providing that reimbursement rates be "reasonably related to the cost of efficient production of such service," properly considered property cost factor of nursing home's new owner in fixing the Medicaid reimbursement rate. *Sands Point Nursing Home v. Ingraham*, 1975, 48 A.D.2d 897, 370 N.Y.S.2d 14.

Ceiling limit on reimbursement rates for nursing home services rendered to publicly assisted patients is not retroactive on rates 1974 rates were insurer as offset to hospital and was not retroactive. *St. Peter v. Ingraham*, 1975, 588, 381 N.Y.S.2d 181, 381 N.Y.S.2d 181, 381 N.Y.S.2d 181, 381 N.Y.S.2d 181.

on other grounds 29 N.Y.2d 10, 272 N.E.2d 524.

Commissioner of Health could set reimbursement rate for home services rendered to assisted patients and state required to reimburse operating nursing home whose costs in excess of ceiling placed on Commissioner. *Sigety v. In- 1971, 29 N.Y.2d 110, 324 N.Y.2d 10, 272 N.E.2d 524.*

Commissioner of Health in limiting Medicaid reimbursement for nursing home services rendered to publicly assisted patients is not to be disturbed if it is reasonable basis and is not arbitrary or capricious. *Id.*

Commissioner of Health need not reimburse nursing facilities, with respect to Medicaid, at a rate that is reasonably related to the costs of the services performed and need not reimburse for actual costs. *Broadacres Nursing Facility v. Ingraham, 51 A.D.2d 243, 391 N.Y.S.2d*

Commissioner of Health, whereby, if a specific group of facilities contains too few institutions to allow the calculation of a meaningful Medicaid reimbursement rate, institutions are allowed to be grouped with others similarly situated, provided the grouping is valid and not in conflict with any requirement that reimbursement rates be reasonably related to costs. *Id.*

Commissioner of Health, acting pursuant to mandate of subd. 3 of this section providing that rates be "reasonably related to the cost of efficient production of such service," properly considered property cost factor of nursing home's new owner in fixing Medicaid reimbursement rate. *Point Nursing Home v. Ingraham, 1975, 48 A.D.2d 897, 370 N.Y.2d 14.*

Commissioner of Health and Superintendent of Insurance that hospital not be given increase in reimbursement rates paid by Associated Hospital Service of New York for years 1970 and 1971 not arbitrary or capricious, but should be modified to extent of increase in recomputation of 1970 non-nursing costs the cost of cardiac intensive care unit. *Presbyterian Hospital in City of New York v. Ingraham, 1975, 48 A.D.2d 491, 369 N.Y.2d 738.*

Commissioner of Health including community service factor in formula for determining reimbursement rates to be paid hospital

by Associated Hospital Service of New York was not arbitrary or capricious. *Id.*

Under regulation providing that a hospital is entitled to receive funds in accord with its prospective reimbursement rate, regardless of actual cost, fact that voluntary, not-for-profit hospital failed to show actual financial loss in its Medicaid program did not preclude it from effectuating a retroactive revision of its Medicaid reimbursement rates after Commissioner of Department of Health had reduced actual reimbursement rate from level of prospective reimbursement rate. *St. Luke's Hospital Center v. Ingraham, 1975, 85 Misc.2d 588, 381 N.Y.S.2d 162, affirmed 52 A.D.2d 181, 383 N.Y.S.2d 324.*

Decision of Commissioner of Health and Superintendent of Insurance approving withholding of payment, which had been made for period hospital was closed due to hurricane damage, which was based on amount medical insurer estimated it would have paid hospital if hospital had not closed, and which was conditioned on recoupment when hospital's 1974 rates were computed, by medical insurer as offset against future payments to hospital had reasonable basis and was not arbitrary or capricious. *St. Joseph's Hospital v. Whalen, 1975, 84 Misc.2d 206, 374 N.Y.S.2d 529.*

Regulation of Commissioner of Department of Health, insofar as it provided that in computing medical reimbursement rate for nursing homes connected with a hospital the maximum allowable costs could be no more than 115% of weighted average costs before ceilings of free standing nursing homes comparable to size, location and sponsor, might have been applied so as to exclude a reasonable cost in violation of subd. 3 of this section directing the Commissioner to relate his rates to costs of efficient production of hospital or health-related service, where skilled nursing facility at hospital was compared with private sector nursing homes which did not incur substantial mandatory pension payments for public employees. *Board of Monroe Community Hospital v. Ingraham, 1975, 80 Misc.2d 950, 364 N.Y.S.2d 795.*

Ceiling limitation procedure set forth in regulations of Commissioner of Department of Health for computing medical reimbursement rates paid to medical facilities for services rendered to publicly assisted patients was consistent with statutory directive to reimburse only reasonable costs. *Id.*

3. Adequacy of rates

If Commissioner of State Department of Health and Superintendent of Insurance department, in certifying and approving rate schedules for payment to hospitals by associated hospital service, considered wage and price increase limitation contained in federal program merely as factor in projecting economic conditions, they did so appropriately; however, to extent they imposed limitation as an absolute ceiling on projected increases in costs, without regard to whether it was in fact reasonably related to the actual increase in costs, the rate schedule did not meet requirements of subd. 3 of this section. *Presbyterian Hospital in City of New York v. Ingraham, 1974, 78 Misc.2d 152, 355 N.Y.S.2d 73.*

5. Efficient production cost basis

Commissioner of State Department of Health and Superintendent of Insurance did not act arbitrarily or capriciously in concluding that 1973 rate schedules for payment to hospitals by associated hospital service were in fact reasonably related to costs of efficient production. *Presbyterian Hospital in City of New York v. Ingraham, 1974, 78 Misc.2d 152, 355 N.Y.S.2d 73.*

6. Reimbursement of expenses

Joinder of director of budget was not essential for complete adjudication of issue of whether rate of reimbursement for Medicaid established by Department of Health had been determined in arbitrary fashion and without regard to laws governing the fixing of such rates. *Catholic Medical Center of Brooklyn & Queens, Inc. v. Department of Health, 1976, 85 Misc.2d 14, 378 N.Y.S.2d 302.*

Where formula provided by law for determining rates of reimbursement for Medicaid to hospitals was abandoned by Department of Health and method selected was not mandated by any law, the method was arbitrary and rates fixed must be vacated. *Id.*

Subdivision 3 of this section providing that Commissioner of State Department of Health shall certify to Superintendent of Insurance and State Director of Budget that proposed rate schedules for payments for hospital and health related services are reasonably related to costs of efficient production of such service does not require reimbursement for all efficiency incurred expenses. *Presbyterian Hospital in City of New York v. Ingraham, 1974, 78 Misc.2d 152, 355 N.Y.S.2d 73.*

Rules and regulations relative to Medicaid and Blue Cross reimburse-

Note 6

PUBLIC HEALTH LAW

7. Hearing

8. Petition for review

9. Review

Supreme Court had subject matter jurisdiction in Article 78 proceeding for review of reimbursement rates

1. All financial statements or financial information required by law or regulation to be submitted by a nursing home or facility providing health-related service shall be certified in their entirety by an independent certified public accountant or independent public accountant. The commissioner shall by regulation establish the form of certification which shall ensure that the certified public accountant or public accountant:

(b) during the period of his professional engagement, at the time of expressing his opinion, or during the period covered by the financial statements, did not have nor was committed to acquire, any direct financial interest or material indirect financial interest in the ownership or operation of the nursing home or facility; and

(d) subsequent to such certification discloses any material fact discovered by him which existed at the time of such certification and was

Determination of commissioner of Department of Health with respect to reimbursement rate for skilled nursing facility of a publicly supported hospital is subject to judicial review. Id.

10. Adjustments for overpayments

Where audit conducted by state of private nursing home established disallowable costs and resultant overpayment of medicaid to operator who did not appeal the findings of audit, state was entitled to recoup amount of overpayment by deductions from current medicaid reimbursements to operator. Id.

Added L.1975.

1976 Amendment

1976, c. 648, §
provided for the
independent publi

Effective Date
Sept. 1, 1975,
c. 655, § 2.

§ 2808. Resid

b. The commercial real property company, on September, nineteen, transferred all residential housing to the ownership of the facility and the facility as of that date and all prior to that date and arm's length factors as to

2. The commission of the budget shall exclude the costs incurred by political parties; the commissioner;

ed by Department of Health
ital and health related ser-
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se law that hospital rates for
patients be established,
or reviewed by the state
ioner of Public Health. Ed-
Whelan, 1975, 82 Misc.2d 952.
S.2d 71.

ustments for overpayments
commissioner determined
rent medicaid reimbursement
operator of private nursing
d only after current rate was
ed was a deduction made for
th of the prior overpayments
successive months, action of
ioner in deducting prior over-
ts did not constitute alteration
caid reimbursement rates as
y established for operator.
v. Whalen, 1975, 84 Misc.2d
76 N.Y.S.2d 819.

e audit conducted by state of
nursing home established dis-
le costs and resultant over-
t of medicaid to operator who
appeal the findings of audit,
as entitled to recoup amount
payment by deductions from
medicaid reimbursements to
or. Id.

ments and financial informa-

information required by law
g home or facility providing
their entirety by an inde-
pendent public accountant.
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with the ownership, financing
ility as a director, officer or
as an independent certified
ccountant; and
discloses any material fact dis-
of such certification and was

not disclosed in the financial statements or financial information, the disclosure of which is necessary to make the financial statements or financial information not misleading and discloses any material misstatement in said financial statements or financial information.

2. Any person submitting a financial statement or financial information which he knows to be false or certifying a financial statement or financial information which he knows to be false shall be guilty of a class E felony.

Added L.1975, c. 655, § 1; amended L.1976, c. 648, § 1.

1976 Amendment. Subd. 1. L. Library References
1976, c. 648, § 1, eff. July 21, 1976, Asylums § 3.
provided for the certification by an C.J.S. Asylums § 5.
independent public accountant.

Effective Date. Section effective
Sept. 1, 1973, pursuant to L.1975,
c. 655, § 2.

§ 2808. Residential health care facilities; rates of payment

1. a. The commissioner shall promulgate interim regulations to expire no later than the thirty-first day of December, nineteen hundred seventy-six, that will relate the rate of payment for each residential health care facility to the operation and program management of the facility, as well as to the quality of patient care provided by the facility. Such regulations shall be consistent with regulations promulgated under the provisions of title eighteen of the federal social security act, by which payment for costs incurred by a residential health care facility for a quantity and quality of supplies or services necessary for the proper operation of a residential health care facility shall not exceed those which would be paid in the normal course of business by a prudent buyer of such supplies or services.

b. The commissioner shall promulgate interim regulations regarding real property costs to expire no later than the thirty-first day of December, nineteen hundred seventy-six, which shall be applicable to all residential health care facilities, regardless of the form of ownership of the facility, and shall be based upon a cost valuation basis of the facility as determined by the commissioner, who may disregard any and all prior transactions involving the property which are not bona fide and arm's length transactions. The commissioner shall consider such factors as the age, size, location and condition of the facility.

c. The commissioner shall submit recommendations to the governor, president pro tem of the senate and speaker of the assembly by the first day of February, nineteen hundred seventy-six, on proposed legislation which will relate the rate of payment for each residential health care facility to the operation and program management of the facility, as well as to the quality of patient care provided by the facility. The commissioner shall further submit recommendations to the governor, president pro tem of the senate and the speaker of the assembly by the first day of February, nineteen hundred seventy-six, for the establishment of a reimbursement system for the construction costs and real property value of existing residential health care facilities and new residential health care facilities which will take into consideration all factors including location of the facility, age, size and depreciation as well as a formula to be established for the bona fide transfer and sale of residential health care facilities on and after the first day of February, nineteen hundred seventy-six.

2. The commissioner, in determining and certifying to the director of the budget the rates of payment to residential health care facilities, shall exclude the following costs: (a) contributions or other payments to political parties, candidates or organizations; (b) direct or indirect costs incurred for advertising or promotion except as allowed by the commissioner; (c) costs incurred for the promotion or opposition, di-

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PUBLIC HEALTH LAW

rectly or indirectly, of the passage of bills or resolutions pending before or passed by a legislative body of any jurisdiction; (d) costs which principally afford diversion, entertainment or amusement to their owners, operators or employees not properly related to patient care or treatment; (e) any penalty imposed by governmental agencies or courts, and the costs of policies obtained solely to insure against the imposition of such a penalty; and (f) costs incurred by the residential health care facility to obtain the security required under the provisions of section twenty-eight hundred nine of this chapter.

Added L.1975, c. 649, § 7; amended L.1975, c. 650, § 2.

1975 Amendment. Subd. 1, par. b. L.1975, c. 650, § 2, eff. Aug. 6, 1975, inserted "regarding real property costs" and substituted "applicable" for "uniform in application" and "a cost valuation basis" for "the actual cost."

Former Section 2808. Renumbered 2811.

Effective Date. Section effective Aug. 6, 1975, pursuant to L.1975, c. 649, § 9.

§ 2808-a. Liability of certain persons

1. Every person who is a controlling person of any residential health care facility liable under any provision of this article to any person or class of persons for damages or to the state for any civil fine, penalty, assessment or damages, shall also be liable, jointly and severally, with and to the same extent as such residential health care facility, to such person or class of persons for damages or to the state for any such civil fine, penalty, assessment or damages.

2. For purposes of this section, a "controlling person" of a residential health care facility shall be deemed to mean any person who by reason of a direct or indirect ownership interest (whether of record or beneficial) has the ability, acting either alone or in concert with others with ownership interests, to direct or cause the direction of the management or policies of said facility. Neither the commissioner nor any employee of the department nor any member of a local legislative body of a county or municipality, nor any county or municipal official except when acting as the administrator of a residential health care facility, shall, by reason of his or her official position, be deemed to be a controlling person of any residential health care facility nor shall any person who serves as an officer, administrator or other employee or as a member of a board of directors or trustees of any facility be deemed to be a controlling person of said facility as a result of such position or his or her official actions in such position.

Added L.1975, c. 651, § 1; amended L.1976, c. 472, § 1.

1976 Amendment. Subd. 2. L.1976, c. 472, § 1, eff. July 1, 1976, inserted "by reason of a direct or indirect ownership interest (whether of record or beneficial)" substituted "acting either alone or in concert with others with ownership interests" inserted "nor any member of a local legislative body of a county or municipality, nor any county or municipal official except when acting as the administrator of a residential health care facility," substituted "his or her" for "their", inserted "administrator or other employee," and substituted "as a result" for "solely by reason."

Effective Date. Section effective July 1, 1976, pursuant to L.1975, c. 651, § 2.

Library References

Asylums § 7.
C.J.S. Asylums § 9.

§ 2809. Residential health care facilities; powers to require security

1. If a residential health care facility receives a rating in the lowest category which may be assigned pursuant to subdivision one of section twenty-eight hundred three of this chapter, the commissioner may require, as a condition of continuing to operate, that the facility obtain financial security to ensure that future obligations will be met, which security may be of a form that the commissioner deems appropriate,

and which shall be maintained by the facility in a conspicuous place where it may be seen by the public. The commissioner may, at any time, require the facility to provide a copy of the security agreement to the commissioner.

2. If the commissioner determines that the facility is in violation of the security agreement, the commissioner may, at any time, require the facility to provide a copy of the security agreement to the commissioner.

3. If for any reason the facility is partially or completely depleted, either the commissioner or the facility, after considering the requirement of the security agreement, but in no case shall the facility be required to provide a copy of the security agreement to the commissioner at any time.

Added L.1975, c. 649, § 9.
Former Section 2812.

§ 2810. Resident

1. The owner of a residential health care facility by the request, the department may, at any time, require the owner to provide a copy of the security agreement to the commissioner. The commissioner may, at any time, require the owner to provide a copy of the security agreement to the commissioner.

2. a. As a condition of the patients in a residential health care facility, the commissioner may, at any time, require the owner to provide a copy of the security agreement to the commissioner. The commissioner may, at any time, require the owner to provide a copy of the security agreement to the commissioner.

44 McKinney 55
1976 P.P.

5.

Chapter 76 of the Laws of 1976

Medical Assistance and Home Relief Programs—
Expenditures—Emergency Controls

Memoranda relating to this chapter, see pages 2288, 2433

CHAPTER 76

An Act to amend the social services law, the public health law and the education law, in relation to emergency controls of expenditures under the medical assistance program and the home relief program.

Approved March 30, 1976, effective as provided in section 18.

Passed on message of necessity. See Const. art. IX, § 2(b)(2), and McKinney's Legislative Law § 44.

The People of the State of New York, represented in Senate and Assembly, do enact as follows:

Section 1. New York has a long, proud history of providing generously for people in need, and the legislature has no intention of forsaking that history. It is recognized, however, that the state and local governments are facing emergency fiscal crises of staggering proportions, and cannot continue to support the scope and level of assistance, care and services the cost of which has sharply escalated in recent years. In order to assure that funds are available for essential and critical medical services, that basic medical necessities for the needy are provided, and that critical assistance, care and health services will be available to all of the people, the legislature, pursuant to the constitution of the state of New York, hereby finds and declares that a state of emergency exists and hereby confers emergency powers on the governor to take such steps as are necessary to implement the following controls on medical assistance and public assistance expenditures.

§ 2. Section three hundred sixty-five-a of the social services law is hereby amended by adding thereto a new subdivision, to be subdivision four, to read as follows:

4. Any inconsistent provision of law notwithstanding, medical assistance shall not include, unless required by federal law and regulation as a condition of qualifying for federal financial participation in the medicaid program drugs which may be dispensed without a prescription as required by section sixty-eight hundred ten of the education law; provided, however, that the state commissioner of health may by regulation specify certain of such drugs which may be reimbursed as an item of medical assistance in accordance with the price schedule established by such commissioner.

§ 3. Section three hundred sixty-five-a of such law is hereby amended by adding thereto a new subdivision, to be subdivision five, to read as follows:

5. (a) Medical assistance shall include surgical benefits for emergency or urgent surgery for the alleviation of severe pain, for immediate diagnosis or treatment of conditions which threaten disability or death if not promptly diagnosed or treated.

(b) Medical assistance shall include surgical benefits for certain surgical procedures which meet standards for surgical intervention, as established by the state commissioner of health on the basis of

medically indicated risk factors, and medically necessary surgery where delay in surgical intervention would substantially increase the medical risk associated with such surgical intervention.

(c) Medical assistance shall include surgical benefits for other deferrable surgical procedures specified by the state commissioner of health, based on the likelihood that deferral of such procedures for six months or more may jeopardize life or essential function, or cause severe pain; provided, however, such procedures shall be included in the case of in-patient surgery, except surgery authorized pursuant to paragraph (a) of this subdivision, only when a second written opinion is obtained from a physician, or as otherwise prescribed, in accordance with regulations established by the state commissioner of health, that such surgery should not be deferred.

(d) Medical assistance shall include a maximum of one patient day of pre-operative hospital care for surgery authorized by paragraphs (b) or (c) of this subdivision; provided, however, that with respect to specific surgical procedures which the state commissioner of health has identified as requiring more than one patient day of pre-operative care, medical assistance shall include such longer maximum period of pre-operative care as such commissioner has identified as necessary.

(e) Medical assistance shall not include any in-patient surgical procedures or any care, services or supplies related to such surgery other than those authorized by this subdivision.

§ 4. Paragraph (b) of subdivision two of section three hundred sixty-five-a of such law, as amended by chapter six hundred ninety-four of the laws of nineteen hundred seventy-two, is hereby amended to read as follows:

(b) care, treatment, maintenance and nursing services in hospitals, nursing homes that qualify as providers in the medicare program pursuant to title XVIII of the federal social security act,¹ infirmaries or other eligible medical institutions, and health-related care and services in intermediate care facilities, while operated in compliance with applicable provisions of this chapter, the public health law, the mental hygiene law and other laws, including any provision thereof requiring an operating certificate or license, or where such facilities are not conveniently accessible, in hospitals located without the state; provided, however, that care, treatment, maintenance and nursing services in nursing homes, including those operated by the state department of mental hygiene or any other state department or agency, shall be limited to one hundred days during any spell of illness for persons who are receiving or are eligible for medical assistance under provisions of subparagraph four of paragraph (a) of subdivision one of section three hundred sixty-six of this chapter, plus, with the prior approval of the commissioner of health upon the recommendation of the appropriate medical director, or with the prior approval of the commissioner of mental hygiene in the case of nursing homes operated by the state department of mental hygiene, such additional periods of time as may be necessary in cases of clear need for nursing services; provided, further, that in-patient care, services and supplies in a general hospital shall not exceed such standards as the commissioner of health shall promulgate but in no case greater than twenty days per spell of illness during which all or any part of the cost of such care, services

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and supplies are claimed as an item of medical assistance, unless it shall have been determined in accordance with procedures and criteria established by such commissioner that a further identifiable period of in-patient general hospital care is required for particular patients to preserve life or to prevent substantial risks of continuing disability;

¹ 42 U.S.C.A. § 1395 et seq.

§ 5. Paragraph (b) of subdivision two of section three hundred sixty-six of such law, as amended by chapter thirty-two of the laws of nineteen hundred sixty-eight, is hereby amended to read as follows:

(b) In establishing standards for determining eligibility for and amount of such assistance, the department shall take into account only such income and resources, in accordance with federal requirements, as are available to the applicant or recipient and as would not be required to be disregarded or set aside for future needs, and there shall be a reasonable evaluation of any such income or resources. There shall not be taken into consideration the financial responsibility of any individual for any applicant or recipient of assistance under this title unless such applicant or recipient is such individual's spouse or such individual's child who is under twenty-one. In the application of standards of eligibility with respect to income, costs incurred for medical care, whether in the form of insurance premiums or otherwise, shall be taken into account. Any person who is eligible for, or reasonably appears to meet the criteria of eligibility for, benefits under title XVIII of the federal social security act¹ shall be required to apply for and fully utilize such benefits in accordance with this chapter.

¹ 42 U.S.C.A. § 1395 et seq.

§ 6. The opening paragraph of section three hundred sixty-seven of such law is hereby designated to be subdivision one thereof, and such section is hereby amended by adding thereto a new subdivision, to be subdivision two, to read as follows:

2. Notwithstanding any inconsistent provision of law, the social services official responsible for authorizing hospital or health related services shall withhold payment for such services upon the certification of the commissioner of health that such care is inappropriate or unnecessary.

§ 7. Subdivisions four through six of section three hundred sixty-seven-a of such law are hereby renumbered to be subdivisions five through seven, respectively, and a new subdivision, to be subdivision four, is hereby added thereto, to read as follows:

4. No social services district shall make final payments pursuant to title XIX of the federal social security act¹ for benefits available under title XVIII of such act² without documentation that title XVIII claims have been filed and denied.

¹ 42 U.S.C.A. § 1396 et seq.

² 42 U.S.C.A. § 1395 et seq.

§ 8. Subdivisions one and two of section twenty-eight hundred three of the public health law, subdivision one having been amended by chapter six hundred forty-nine of the laws of nineteen hundred seventy-five and subdivision two having been amended by chapter nine hundred fifty-six of the laws of nineteen hundred seventy-four, are hereby amended to read, respectively, as follows:

1. a. (a) The commissioner shall have the power to inquire into the operation of hospitals and home health agencies and to conduct periodic inspections of facilities with respect to the fitness and adequacy of the premises, equipment, personnel, rules and by-laws, standards of medical care, hospital service, including health-related service,

home health service, system of accounts, records, and the adequacy of financial resources and sources of future revenues. The commissioner or persons designated by him shall each year conduct two or more inspections of each residential health care facility, at least one of which shall be unannounced, to determine the adequacy of care being rendered. Any employee of the department who gives or causes to be given advance notice of such unannounced inspection to any unauthorized person shall, in addition to any other penalty provided by law, be suspended by the commissioner from all duties without pay for at least five days or for such greater period of time as the commissioner shall determine. Any such suspension shall be made by the commissioner in accordance with all other applicable provisions of law.

b. (b) The purpose of such inspections shall be to determine compliance by residential health care facilities with statutes, and with regulations promulgated under the provisions of those statutes, governing minimum standards of construction, quality and adequacy of care, rights of patients, rates of payment and reimbursement. At least one such inspection each year shall include, but shall not be limited to, full on-site examination and audit of the medical, nursing care, dietary, social services and financial records of the facility. The on-site audits of financial records shall encompass the immediately preceding complete fiscal year of the residential health care facility, and shall not be conducted in any instance in which an audit of such fiscal year shall already have been completed as part of a previous inspection.

c. (c) The commissioner shall promulgate and publish uniform criteria for the evaluation of residential health care facilities with respect to their compliance with the standards set forth in this section, as indicated by the results of the inspections conducted pursuant to the provisions of this section. Such criteria shall include a detailed listing of the types, and degree of severity or unacceptability, of deficiencies which inspections might indicate, and shall also indicate areas of care and performance in which residential health care facilities notably and significantly exceed required minimum standards. In promulgating such criteria, the commissioner shall devise a system of rating residential health care facilities in accordance with the deficiencies and areas of significantly high care and performance which the reports of inspection shall have indicated. Such system shall include no less than five specific rating categories. The rating assigned to each residential health care facility on the basis of its immediately prior inspection shall be deemed a part of the results and findings of that inspection, and shall be required by the commissioner to be posted conspicuously within the residential health care facility to which it applies. A facility may appeal the assignment of a particular rating to the commissioner within twenty days after notice of its assignment. The results and findings of any prior inspections, and any penalties thereby assessed, which have not been previously appealed and overruled, shall not be subject to review.

(d) Notwithstanding any inconsistent provision of law, the commissioner shall, not later than July first, nineteen hundred seventy-six, determine the necessity and appropriateness of care and services provided by hospitals and home health agencies to individual patients. In making such determinations the commissioner may function through department personnel or other authorized representatives. The hospitals shall provide such information, facilities and services as may be required by the commissioner to make such determinations. The commissioner, in implementing this paragraph, shall adopt necessary rules and regulations including but not limited to those for determining

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the necessity of admission, controlling the length of stay, the provision of surgery and other services, and the methods and procedures for making such determinations. The commissioner shall certify to the social services officials responsible for authorized hospital or health related services that payment for inappropriate or unnecessary care shall be withheld.

2. The council, by a majority vote of its members, shall adopt and amend rules and regulations, subject to the approval of the commissioner, to effectuate the provisions and purposes of this article, including, but not limited to (a) the establishment of requirements for a uniform statewide system of reports and audits relating to the quality of medical and physical care provided, hospital utilization and costs in accordance with section twenty-eight hundred three-b, (b) establishment by the department of schedules of rates, payments, reimbursements, grants and other charges for hospital, health-related services and home health services as provided in section two thousand eight hundred seven (c) standards and procedures relating to hospital operating certificates and home health certificates of approval, provided however, that the council shall establish minimum acceptable standards and procedures equal to the standards and procedures which federal law and regulation require for hospitals to qualify as providers pursuant to titles XVIII and XIX of the federal social security act.¹ The existing state standards and procedures in effect on the date that this section becomes effective shall be deemed to constitute maximum standards and procedures for purposes of limiting medical assistance reimbursement pursuant to the social services law. Such standards and procedures may thereafter be changed or added to by the council only upon the recommendation of the commissioner. For the purposes of ensuring that the health and safety of the residents of hospitals are not endangered, the council may promulgate changes in the minimum acceptable standards and procedures referred to herein upon recommendation of the commissioner. For the purposes of orderly implementation of this subdivision, the commissioner of health may grant waivers to maximum reimbursable standards to expire no later than March thirty-first, nineteen hundred seventy-eight and (d) the establishment of a system of accounts and cost findings to be used by hospitals, including a classification of such hospitals and the prescription of a system of accounts and cost finding for each class in accordance with section twenty-eight hundred three-b. The commissioner may propose rules and regulations and amendments thereto for consideration by the council.

¹ 42 U.S.C.A. § 1395 et seq.; 42 U.S.C.A. § 1396 et seq.

§ 9. Section twenty-eight hundred six of such law is hereby amended by adding thereto a new subdivision, to be subdivision five, to read as follows:

5. (a) Notwithstanding the provisions of subdivisions two through four of this section, the commissioner shall suspend, limit or revoke a general hospital operating certificate, after taking into consideration the total number of beds necessary to meet the public need, and the availability of facilities or services such as preadmission, ambulatory, home care or other services which may serve as alternatives or substitutes for the whole or any part of any such hospital facility, and after finding that suspending, limiting, or revoking the operating certi-

ificate of such facility would be within the public interest in order to conserve health resources by restricting the number of beds and/or the level of services to those which are actually needed.

(b) Whenever any finding as described in paragraph (a) of this subdivision is under consideration with respect to any particular facility, the commissioner shall cause to be published, in a newspaper of general circulation in the geographic area of the facility at least thirty days prior to making such a finding an announcement that such a finding is under consideration and an address to which interested persons can write to make their views known. The commissioner shall take all public comments into consideration in making such a finding.

(c) The commissioner shall, upon making any finding described in paragraph (a) of this subdivision with respect to any facility, cause such facility and the appropriate health systems agency to be notified of the finding at least thirty days in advance of taking the proposed action to revoke, suspend or limit the facility's operating certificate. Upon receipt of any such notification and before the expiration of the thirty days or such longer period as may be specified in the notice, the facility or the appropriate health systems agency may request a public hearing to be held in the county in which the hospital is located. In no event shall the revocation, suspension or limitation take effect prior to the thirtieth day after the date of the notice, or prior to the effective date specified in the notice or prior to the date of the hearing decision, whichever is later.

(d) Except as otherwise provided by law, all appeals from a finding of the commissioner made pursuant to paragraph (a) of this subdivision shall be directly to the appellate division of the supreme court in the third department. Except as otherwise expressly provided by law, such appeals shall have preference over all issues in all courts.

§ 10. Subdivision one of section twenty-eight hundred seven of such law, as amended by chapter nine hundred eighteen of the laws of nineteen hundred seventy-two, is hereby amended to read as follows:

1. No government agency and no corporation organized and operating in accordance with article nine-c of the insurance law shall purchase, pay for or make reimbursement or grants-in-aid for any hospital or health-related service, including home health service, unless, at the time the service was provided, the hospital possessed a valid operating certificate authorizing such service or in the case of a home health agency a valid certificate of approval. No government agency shall purchase, pay for or make reimbursement or grants-in-aid for any hospital or health related service, including home health services that have been determined by the commissioner of health to be unnecessary or inappropriate under section twenty-eight hundred three of this title.

§ 11. Subdivision two of section twenty-eight hundred seven of such law, as amended by chapter nine hundred eighteen of the laws of nineteen hundred seventy-two, is hereby amended to read as follows:

2. (a) Payments for hospital service and health-related service, including home health service, made by government agencies or corporations organized and operating in accordance with article nine-c of the insurance law¹ shall be at rates approved by the state director of the budget in the case of government agencies and approved by the super-

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intendent of insurance in the case of corporations organized and operating under article nine-c of the insurance law.

(b) Notwithstanding the foregoing provisions of paragraph (a) above, rates of payment for hospital and health-related service made by government agencies, approved by the state director of the budget and in effect March thirty-first, nineteen hundred sixty-nine shall continue in effect for the period ending December thirty-first, nineteen hundred sixty-nine. Rates approved by the state director of the budget for the first time after March thirty-first, nineteen hundred sixty-nine shall continue in effect for the period ending December thirty-first, nineteen hundred sixty-nine.

(c) Notwithstanding any inconsistent provision of law, rates of payment for government agencies for general hospital out-patient and emergency services, and for treatment or diagnostic center services during the period January first, nineteen hundred seventy-six through March thirty-first, nineteen hundred seventy-seven shall be at no more than one hundred percent of the approved nineteen hundred seventy-five rates for such services.

(d) For the purpose of this subdivision approved nineteen hundred seventy-five rates shall mean those rates originally approved by the state director of the budget, together with any approved rate revisions. Nothing contained herein shall be deemed to preclude further revisions as the result of audits conducted pursuant to section twenty-eight hundred three of this chapter.

(e) During the period beginning January first, nineteen hundred seventy-six, and ending March thirty-first, nineteen hundred seventy-seven, the commissioner may determine and certify to the director of the budget rates of payment for residential health care facilities without regard to the provisions of subdivision three of this section. The commissioner is directed to formulate such rates in accordance with the provisions of paragraph c of subdivision one of section twenty-eight hundred three and section twenty-eight hundred eight of this chapter which rates shall be effective for the period hereinbefore specified in this paragraph notwithstanding any inconsistent provision of such section twenty-eight hundred eight.

¹ Insurance Law § 250 et seq.

§ 12. Section twenty-eight hundred seven of such law is hereby amended by adding thereto two new subdivisions, to be subdivisions two-a and two-b, to read, respectively, as follows:

2-a. Prior to the approval of rates of payment for hospitals, exclusive of residential health care facilities and outpatient and emergency services and treatment and diagnostic centers, made by government agencies, the state director of the budget shall take into consideration economic conditions within the state which affect the economic resources available to meet the cost of government-funded medical services. If economic conditions are determined by such director to be likely to have a severe adverse effect on the ability of the state government to make sufficient resources available to purchase medical care at the proposed rates, the director shall return the proposed rates to the commissioner, and direct him to revise the rates to comply with the director's finding. Such revised rates shall not be certified to the

superintendent of insurance for corporations organized and operating in accordance with article nine-C of the insurance law¹ which corporations shall continue to be subject to the rates of payment otherwise established pursuant to law.

2-b. There shall be a hospital rate review board in the department consisting of the comptroller, the director of the budget, the commissioner of health who shall serve as chairman, one member appointed by the governor upon nomination by the temporary president of the senate, and one member appointed by the governor upon nomination by the speaker of the assembly. The members appointed by the governor upon the nomination of the temporary president of the senate and the speaker shall receive reimbursement for actual and necessary expenses. The board shall hear appeals from the rate determinations made pursuant to subdivision two-a of this section. The board shall uphold the decision of the director of the budget unless the appellant can establish that: the rate of payment allowed is inadequate to provide care equal to that required to meet minimum acceptable standards and procedures required by section twenty-eight hundred three of this article; and that the costs of providing such care are reasonably related to the efficient production of medical care and services. Whenever the board shall find that the rate of payment is insufficient to provide for the efficient production of medical care and services equal to that required to meet the minimum acceptable standards and procedures required by section twenty-eight hundred three, it shall direct the commissioner of health to certify a revised rate of payment sufficient to meet such standards.

¹ Insurance Law § 250 et seq.

§ 13. Section twenty-eight hundred seven of such law is hereby amended by adding thereto a new subdivision, to be subdivision four, to read as follows:

4. The commissioner shall notify each hospital and health-related service of its approved rate at least sixty days prior to the beginning of an established rate period for which the rate is to become effective.

§ 14. Section sixty-eight hundred sixteen of the education law is hereby amended by designating the text thereof as subdivision one, and by adding thereto a new subdivision, to be subdivision two, to read as follows:

2. For the purposes set forth in this section, the terms prescription, order or demand shall apply only to those items subject to provisions of subdivision one of section sixty-eight hundred ten of this chapter. The written order of a physician for items not subject to provisions of subdivision one of section sixty-eight hundred ten of this chapter shall be construed to be a direction, a fiscal order or a voucher.

§ 15. Subdivision (a) of section one hundred fifty-eight of the social services law, as amended by chapter one hundred ninety-eight of the laws of nineteen hundred seventy-five, is hereby amended to read as follows:

(a) Any person unable to provide for himself, or who is unable to secure support from a legally responsible relative, who is not receiving needed assistance or care under other provisions of this chapter, or from other sources, shall be eligible for home relief; provided, however that no person under the age of twenty-one years except a

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married person living with their spouse, living apart from a legally responsible relative shall be eligible for home relief unless a proceeding has been brought by or on behalf of such person to compel such legally responsible relative to provide for or contribute to such person's support and until an order of disposition has been entered in such proceeding. However, a person who shall be eligible for aid to dependent children according to the provisions of title ten of this article¹ shall be granted aid to dependent children and while receiving such aid shall not be eligible for home relief. A person who is receiving federal supplemental security income payments and/or additional state payments shall not be eligible for home relief. An applicant for home relief who reasonably appears to meet the criteria for eligibility for federal supplemental security income payments shall be required, as a condition of eligibility for home relief, to apply for such payments and shall, if otherwise eligible therefor, be eligible for home relief until he has received a federal supplemental security income payment. Such applicant shall also be required, as a condition of eligibility for home relief, to sign a written authorization allowing the secretary of the federal department of health, education and welfare to pay to the social services district his initial supplemental security income payment and allowing the social services district to deduct from his initial payment the amount of home relief granted for any month in which he had applied for and been found eligible for supplemental security income benefits.

¹ Social Services Law § 343 et seq.

§ 16. The effectiveness of the provisions of subdivision four of section twenty-eight hundred seven of the public health law, as added by chapter six hundred eighty-two of the laws of nineteen hundred seventy-four, are hereby suspended and shall, for all purposes whatsoever, be deemed to have been without any force or effect from and after November first, nineteen hundred seventy-five.

§ 17. If any provision of this act, or the application thereof to any person or circumstance, be held unconstitutional, invalid or ineffective, in whole or in part, the remainder of this act, or the application of such provision to persons or circumstances other than those to which it was held unconstitutional, invalid or ineffective, shall not be affected thereby. If any exception to any limitation on the care, services or supplies that may be furnished as an item of medical assistance as provided for in this act be held unconstitutional, invalid or ineffective, the limitation shall remain in effect without any exception.

§ 18. This act shall take effect immediately; provided, however, that sections two and fourteen shall take effect on the thirtieth day next succeeding such effectiveness, sections three, four, five, six, seven, ten and fifteen shall take effect on the forty-fifth day next succeeding such effectiveness, sections eight, eleven and twelve shall be deemed to have been in full force and effect on and after the first day of January, nineteen hundred seventy-six. Provided, however, that the provisions of sections twelve, thirteen and sixteen of this act shall be and remain effective only to and including March thirty-first, nineteen hundred seventy-seven and shall be thereafter effective only in respect to any act done on or before such date or action or proceeding arising out of such act. The state commissioners of health, social services and education shall, prior to such effective dates, take all necessary steps to inform providers and recipients of medical assistance of the provisions of this act and are authorized to take such other steps as may be necessary to effectuate the purposes of this act. This act shall apply to care, services and supplies furnished on and after the applicable ef-

fective date. This act shall not be construed to alter, change, affect, impair or defeat any rights, obligations, duties or interests accrued, incurred or conferred prior to the enactment of this act, nor shall this act be interpreted so as to deny care, services or supplies to any individual if such care, services and supplies are necessary in order to complete a course of treatment initiated prior to the enactment of this act.

Education—Licenses, Permits, Etc.—Fees, Appropriations

CHAPTER 77

An Act to amend the education law, in relation to fees for professional examinations, limited permits, licenses and miscellaneous registration fees, and making an appropriation therefor.

Approved March 30, 1976, effective April 1, 1976.

The People of the State of New York, represented in Senate and Assembly, do enact as follows:

Section 1. Section one hundred ten of the education law is hereby amended to read as follows:

§ 110. Refunds

1. Moneys received by the state education department pursuant to this chapter prior to July first, nineteen hundred forty-two, may be refunded: (a) Where such moneys were not required by law or regents' rule. (b) Where such moneys were in excess of the amounts required by law or regents' rule. (c) Where fees are paid by applicants who are not permitted to enter examinations for which such fees are paid. Any such moneys received after July first, nineteen hundred forty-two shall not be so refunded unless application for such refund has been made within two years after its receipt by the state education department.

2. Applicants for professional licenses not receiving such licenses may be granted partial refunds not exceeding fifty percent of the fee paid to the department unless they have failed the examinations for such licenses, in which case such applicants may not receive a refund. Each applicant for a professional license who has at any time received a partial refund of an initial license application fee shall pay all required fees upon submitting any subsequent application for initial licensure.

§ 2. Section two hundred twelve of such law, as amended by chapter six hundred ninety-one of the laws of nineteen hundred fifty-seven, is hereby amended to read as follows:

§ 212. Fees

The department shall charge the following fees:

1. For the issuance of a qualifying certificate for admission to a professional school as required by or pursuant to law, five dollars.
2. For admission to a special examination in English authorized or required by or pursuant to law as a pre-requisite to admission to a professional school or to an examination for a license to engage in or practice a profession, ten dollars.
3. For replacement licenses, duplicate registration certificates, detailed certifications of licensure records and other certifications or permits for which fees are not otherwise provided, fees as fixed by regulations of the department.

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6.

20 C.F.R. §§405.401, 405.402, 405.451, 405.455,
405.460 (Principles of Reimbursement under Medicare)

Subpart D

**PRINCIPLES OF REIMBURSEMENT FOR PROVIDER COSTS
AND FOR SERVICES BY HOSPITAL-BASED PHYSICIANS,
APPEALS BY PROVIDER****[Principles of Reimbursement for Provider Costs]**

[[18,933] Regulation Sec. 405.401. Introduction.—(a) Under the health insurance program for the aged, the amount paid to any provider of services—i. e., hospital, skilled nursing facility, or home health agency—for the covered services furnished to beneficiaries is required by section 1814(b) and section 1833(a)(2) of the Act to be the reasonable costs of such services subject to the provisions of §§ 405.455 and 405.460.

(b) These principles of reimbursement and the related policies described in this subpart establish the guidelines and procedures to be used by institutional providers, fiscal intermediaries, and the Social Security Administration in determining reasonable cost.

(c) The principles of reimbursement are to be applied on behalf of the program by public and private organizations and agencies acting as fiscal intermediaries in the payment of claims. These organizations and agencies are selected after nomination by groups or associations of hospitals. Extended care facilities and home health agencies may similarly nominate such intermediaries. The fiscal intermediaries are responsible for paying the bills of beneficiaries for covered services received in participating hospitals and other institutions under the medicare program. A provider may deal directly with the Social Security Administration, in which case the same principles are to be used in making payment for services.

(d) In consideration of the wide variations in size and scope of services of providers and regional differences that exist, the principles are flexible on many points. They offer certain alternatives and options designed to fit individual circumstances and to allow time for those providers who do not already collect the statistical and financial data necessary for the reporting of costs to develop the necessary records.

(e) An important role of the fiscal intermediary, in addition to claims processing and payment, and other assigned responsibilities, is to furnish consultative services to providers in the development of accounting and cost-finding procedures which will assure them equitable payment under the program.

.01 Source:

As adopted, 31 F. R. 14808 (Nov. 22, 1966), and amended at 39 F. R. 16882 (May 10, 1974), and at 39 F. R. 20161 (June 6, 1974, effective July 1, 1974).

[[18,934] Regulation Sec. 405.402. Cost reimbursement; general.—

(a) In formulating methods for making fair and equitable reimbursement for services rendered beneficiaries of the program, payment is to be made on the basis of current costs of the individual provider, rather than costs of a past period or a fixed negotiated rate. All necessary and proper expenses of an institution in the production of services, including normal standby costs, are recognized. Furthermore, the share of the total institutional cost that is borne by the program is related to the care furnished beneficiaries so that no part of their cost would need to be borne by other patients. Conversely,

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Reg. § 405.402 ¶ 18,934

costs attributable to other patients of the institution are not to be borne by the program. Thus, the application of this approach, with appropriate accounting support, will result in meeting actual costs of services to beneficiaries as such costs vary from institution to institution. However, payments to providers of services for services rendered health insurance program beneficiaries are subject to the provisions of §§ 405.455 and 405.460.

(b) Putting these several points together, certain tests have been evolved for the principles of reimbursement and certain goals have been established that they should be designed to accomplish. In general terms, these are the tests or objectives:

(1) That the methods of reimbursement should result in current payment so that institutions will not be disadvantaged, as they sometimes are under other arrangements, by having to put up money for the purchase of goods and services well before they receive reimbursement.

(2) That, in addition to current payment, there should be retroactive adjustment so that increases in costs are taken fully into account as they actually occurred, not just prospectively.

(3) That there be a division of the allowable costs between the beneficiaries of this program and the other patients of the provider that takes account of the actual use of services by the beneficiaries of this program and that is fair to each provider individually.

(4) That there be sufficient flexibility in the methods of reimbursement to be used, particularly at the beginning of the program, to take account of the great differences in the present state of development of recordkeeping.

(5) That the principles should result in the equitable treatment of both nonprofit organizations and profitmaking organizations.

(6) That there should be a recognition of the need of hospitals and other providers to keep pace with growing needs and to make improvements.

(c) As formulated herein, the principles give recognition to such factors as depreciation, interest, bad debts, educational costs, compensation of owners, and an allowance for a reasonable return on equity capital of proprietary facilities. However, costs such as depreciation, interest on borrowed funds, a return on equity capital (in the case of proprietary providers), and other costs related to certain capital expenditures are subject to the provisions of § 405.435, "Nonallowable costs related to certain capital expenditures." With respect to allowable costs some items of inclusion and exclusion are:

(1) An appropriate part of the net cost of approved educational activities will be included.

(2) Costs incurred for research purposes, over and above usual patient care, will not be included.

(3) Grants, gifts, and income from endowments will not be deducted from operating costs unless they are designated by the donor for the payment of specific operating costs.

(4) The value of services provided by nonpaid workers, as members of an organization (including services of members of religious orders) having an agreement with the provider to furnish such services, is includible in the amount that would be paid others for similar work.

(5) Discounts and allowances received on the purchase of goods or services are reductions of the cost to which they relate.

(6) Bad debts growing out of the failure of a beneficiary to pay the deductible, or the coinsurance, will be reimbursed (after bona fide efforts at collection).

¶ 18,934 Reg. § 405.402

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(7) Charity and courtesy allowances are not includable, although "fringe benefit" allowances for employees under a formal plan will be includable as part of their compensation.

(8) A reasonable allowance of compensation for the services of owners in profitmaking organizations will be allowed providing their services are actually performed in a necessary function.

(9) Reasonable cost of physicians' direct medical and surgical services (including supervision of interns and residents in the care of individual patients) rendered in a teaching hospital may be reimbursed as a provider cost (see § 405.465) where elected as provided for in § 405.521 of this Part.

(d) In developing these principles of reimbursement for the health insurance program, all of the considerations inherent in allowances for depreciation were studied. The principles, as presented, provide options to meet varied situations. Depreciation will essentially be on an historical cost basis but since many institutions do not have adequate records of old assets, the principles provide an optional allowance in lieu of such depreciation for assets acquired before 1966. For assets acquired after 1965, the historical cost basis must be used. All assets actually in use for production of services for title XVIII beneficiaries will be recognized even though they may have been fully or partially depreciated for other purposes. Assets financed with public funds may be depreciated. Although funding of depreciation is not required, there is an incentive for it since income from funded depreciation is not considered as an offset which must be taken to reduce the interest expense that is allowable as a program cost.

(e) [Revoked.]

(f) A return on the equity capital of proprietary facilities is an allowable cost in profitmaking organizations. The rate of return may not exceed one and one-half times the average long-term rate of interest on obligations issued for purchase by the Federal Hospital Insurance Trust Fund.

(g) The Social Security Administration is authorized to issue temporary instructions modifying the provisions of this subpart to the extent it finds appropriate for cost reporting periods ending after June 30, 1973, in order to implement sections 201 (Coverage for Disability Beneficiaries Under Medicare) and 299 I (Chronic Renal Disease Considered to Constitute Disability) of P. L. 92-603. In so doing, rules may be developed for establishing limits on costs and services above which reimbursement shall be made only upon appropriate justification.

.01 Source:

As adopted, 31 F. R. 14808 (Nov 22, 1966), and amended at 32 F. R. 5258 (Mar. 29, 1967), and at 35 F. R. 12330 (Aug. 1, 1970), and at 38 F. R. 17210 (June 29, 1973), and at 39 F. R. 16882 (May 10, 1974), and at 39 F. R. 20164 (June 6, 1974, effective July 1,

1974), and at 40 F. R. 32742 (Aug. 4, 1975, effective with respect to all capital expenditures, the obligation for which is incurred after 1972, or after the effective date of the agreement between the State and the Secretary, whichever is later), and at 40 F. R. 33439 (Aug. 8, 1975, effective Sept. 8, 1975).

[¶ 18,935] Regulation Sec. 405.403. Apportionment of allowable costs.—

(a) Consistent with prevailing practice where third-party organizations pay for health care on a cost basis, reimbursement under the title XVIII health insurance program involves a determination of (1) each provider's allowable costs for producing services, and (2) the share of these costs which is to be borne by title XVIII. The provider's costs are to be determined in accordance with the principles reviewed in the preceding discussion relating to

Reg. § 405.403 ¶ 18,935

Medicare and Medicaid Guide

[§ 18,983] Regulation Sec. 405.451. Cost related to patient care.—
(a) *Principle.* All payments to providers of services must be based on the reasonable cost of services covered under title XVIII of the Act and related to the care of beneficiaries. Reasonable cost includes all necessary and proper costs incurred in rendering the services, subject to principles relating to specific items of revenue and cost. However, for cost reporting periods beginning after December 31, 1973, payments to providers of services are based on the lesser of the reasonable cost of services covered under title XVIII of the Act and furnished to program beneficiaries or the customary charges to the general public for such services, as provided for in § 405.455.

(b) *Definitions.* (1) *Reasonable cost.* Reasonable cost of any services must be determined in accordance with regulations establishing the method or methods to be used, and the items to be included. The regulations in this subpart take into account both direct and indirect costs of providers of services. The objective is that under the methods of determining costs, the costs with respect to individuals covered by the program will not be borne by individuals not so covered, and the costs with respect to individuals not so covered will not be borne by the program. These regulations also provide for the making of suitable retroactive adjustments after the provider has submitted fiscal and statistical reports. The retroactive adjustment will represent the difference between the amount received by the provider during the year for covered services from both title XVIII and the beneficiaries and the amount determined in accordance with an accepted method of cost apportionment to be the actual cost of services rendered to beneficiaries during the year.

(2) *Necessary and proper costs.* Necessary and proper costs are costs which are appropriate and helpful in developing and maintaining the operation of patient care facilities and activities. They are usually costs which are common and accepted occurrences in the field of the provider's activity.

(c) *Application.* (1) It is the intent of title XVIII of the Act that payments to providers of services should be fair to the providers, to the contributors to the health-insurance trust funds, and to other patients.

(2) The costs of providers' services vary from one provider to another and the variations generally reflect differences in scope of services and intensity of care. The provision in title XVIII of the Act for payment of reasonable cost of services is intended to meet the actual costs, however widely they may vary from one institution to another. This is subject to a limitation where a particular institution's costs are found to be substantially out of line with other institutions in the same area which are similar in size, scope of services, utilization, and other relevant factors.

(3) The determination of reasonable cost of services must be based on cost related to the care of beneficiaries of title XVIII of the Act. Reasonable cost includes all necessary and proper expenses incurred in rendering services, such as administrative costs, maintenance costs, and premium payments for employee health and pension plans. It includes both direct and indirect costs and normal standby costs. However, where the provider's operating costs include amounts not related to patient care, specifically not reimbursable under the program, or flowing from the provision of luxury items or services (that is, those items or services substantially in excess of or more expensive than those generally considered necessary for the provision of needed health services), such amounts will not be allowable. The reasonable cost basis of reimbursement contemplates that the providers of services would be reimbursed the actual costs of providing quality care however widely the actual costs may vary from provider to provider and from time to time for the same provider.

(5) A provider's periodic interim payment amount may be appropriately adjusted at any time if the provider presents or the intermediary otherwise obtains evidence relating to the provider's costs or Medicare utilization that warrants such adjustment. In addition, the intermediary will recompute the payment immediately upon completion of the desk review of a provider's cost report and also at regular intervals not less often than quarterly. The intermediary may make a retroactive lump sum interim payment to a provider, based upon an increase in its periodic interim payment amount, in order to bring past interim payments for the provider's current cost reporting period into line with the adjusted payment amount. The objective of intermediary monitoring of provider costs and utilization is to assure payments approximating, as closely as possible, the reimbursement to be determined at settlement for the cost reporting period. A significant factor in evaluating the amount of the payment in terms of the realization of the projected Medicare utilization of services is the timely submittal to the intermediary of completed admission and billing forms. All providers must complete billings in detail under this method as under regular interim payment procedures.

(k) *Bankruptcy or insolvency of provider.* If on the basis of reliable evidence, the intermediary has a valid basis for believing that, with respect to a provider, proceedings have been or will shortly be instituted in a State or Federal court for purposes of determining whether such provider is insolvent or bankrupt under an appropriate State or Federal law, any payments to the provider shall be adjusted by the intermediary, notwithstanding any other regulation or program instruction regarding the timing or manner of such adjustments, to a level necessary to insure that no overpayment to the provider is made.

.01 Source:

As adopted, 31 F. R. 14808 (Nov. 22, 1966), and amended at 32 F. R. 5258 (Mar. 29, 1967), and at 36 F. R. 18643 (Sept. 18, 1971), and at 37 F. R. 21630 (Oct. 13,

1972), and at 38 F. R. 6386 (Mar. 9, 1973), and at 38 F. R. 14092 (May 29, 1973) and at 40 F. R. 29815 (July 16, 1975, effective Aug. 15, 1975).

[§ 18,987] Regulation Sec. 405.455. Amount of payments where customary charges for services furnished are less than reasonable cost.—(a) *Principle.* Providers of services will be paid the lesser of the reasonable cost of services furnished to beneficiaries or the customary charges made by the provider for the same services. Public providers of service rendering services free of charge or at a nominal charge will be paid fair compensation for services furnished to beneficiaries. This principle is applicable to services rendered by providers in cost reporting periods beginning after December 31, 1973.

(b) *Definitions.* (1) *Customary charges.* Customary charges for services rendered to beneficiaries are the charges as defined in § 405.452(d)(4). Such charges must be recorded on all bills submitted for program reimbursement. Where the provider does not actually impose such charges in the case of most patients liable for payment for its services on a charge basis or fails to make reasonable efforts to collect such charges from patients liable for payment for its services on a charge basis, customary charges for services rendered to beneficiaries shall be the charges as defined in § 405.452(d)(4) and recorded on the bills submitted for program reimbursement reduced in proportion to the ratio of the aggregate amount actually collected from patients liable for payment for services on a charge basis to the amounts that would be realized had charges consistent with the charges as defined in § 405.452(d)(4) and recorded on the bills submitted for program reimbursement been paid by or on behalf of all patients liable for payment on a charge basis.

§ 18,987 Reg. § 405.455

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REGULATIONS
Medicare and Medicaid

(2) *Reasonable cost.* For purposes of comparison with customary charges, the reasonable cost of services furnished to beneficiaries shall exclude (i) payments made to a provider as reimbursement for bad debts arising from non-collection of Medicare deductible and coinsurance amounts, (ii) amounts which represent the recovery of excess depreciation resulting from termination, or a decrease in Medicare utilization (§ 405.415(d)(3)) applicable to prior cost periods, (iii) amounts applicable to prior cost periods resulting from disposition of depreciable assets (§ 405.415(f)), and (iv) payments to funds for the donated services of teaching physicians.

(3) *Public provider.* A public provider means any provider operated by a Federal, State, county, city, or other local Government agency or instrumentality.

(4) *Nominal charges.* A public provider's charges are considered nominal where the aggregate charges are less than one-half of the reasonable cost of services or items represented by such charges.

(5) *New provider.* A new provider is an institution that has operated as the type of facility for which it is certified in the program (or the equivalent thereof) under present and previous ownership for less than 3 full years.

(c) *Aggregation of charges.* It is appropriate that, on an aggregate basis, payments to a provider for covered services rendered beneficiaries under title XVIII should not exceed the customary charges made by the provider to the general public for the same services. In comparing charges and costs, customary charges for items and services, and the reasonable cost of such items and services will be aggregated, without regard to whether the related services were reimbursable under Part A or Part B of title XVIII. The principle established is to be applied after the provider's charges and costs have been adjusted in accordance with the requirements set forth in paragraph (b)(2) of this section and in §§ 405.480—405.488, to exclude any amounts attributable to physicians' services not reimbursable to the provider on a reasonable cost basis and to exclude costs and charges with respect to noncovered provider services.

Example. The reasonable cost of covered services furnished to program beneficiaries by a provider for a cost reporting period is \$125,000. The customary charges to these beneficiaries for these services totaled \$110,000. The amount to be reimbursed this provider will be \$110,000 less deductible and coinsurance amounts to be borne by program beneficiaries.

(d) *Accumulation of unreimbursed costs and carryover to subsequent periods.*
—(1) *General.* Any provider of services whose charges are lower than costs in any cost reporting period beginning after December 31, 1973, may carry forward costs attributable to program beneficiaries which are unreimbursed under the provisions of this section for the two succeeding reporting periods. Where beneficiary charges exceed reasonable cost in such subsequent periods, such previously unreimbursed amounts carried forward shall be reimbursed to the provider to the extent that such previously unreimbursed amounts carried forward, together with costs applicable to program beneficiaries in such subsequent periods, do not exceed customary charges with respect to services to program beneficiaries in such subsequent periods. If such two succeeding cost reporting periods combined include fewer than 24 full calendar months, the provider may carry forward costs unreimbursed under this section for one additional reporting period. However, no recovery may be made in any period in which costs are unreimbursed under § 405.460.

Example. In the reporting period ending December 31, 1974, the provider's reimbursable costs attributable to covered services furnished for these services were \$100,000. The provider's customary charges were \$90,000 less any deductible and coinsurance amounts but will be permitted to carry the unreimbursed \$10,000 forward for the next two succeeding reporting periods. If, in the reporting period ending December 31, 1975, the charges to beneficiaries for covered services exceeded the reimbursable reasonable costs of such services by \$10,000 or more, the provider could recover the entire \$10,000 previously not reimbursed. If, however, beneficiary charges exceeded costs by \$8,000, this amount would be added to the provider's reimbursable costs for this period. The balance of the unreimbursed amount or \$2,000 would be carried over to the next reporting period.

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(2) *New provider*—(i) *General*. A new provider of services may carry forward for five succeeding cost reporting periods costs attributable to program beneficiaries which are unreimbursed under the provisions of this section during a base period, which includes any cost reporting period which begins after December 31, 1973, and ends on or before the last day of its third year of operation. Where beneficiary charges exceed reasonable cost in the five succeeding reporting periods, such previously unreimbursed amounts carried forward shall be reimbursed to the provider to the extent that such previously unreimbursed amounts carried forward, together with costs applicable to program beneficiaries in such subsequent periods, do not exceed customary charges with respect to services to program beneficiaries in such subsequent periods. If such five succeeding cost reporting periods combined include fewer than 60 full calendar months, the provider may carry forward costs unreimbursed under this section for one additional reporting period.

Example. A provider begins its operations on March 5, 1972. However, it begins to participate in the Medicare program as of January 1, 1973, and reports on a calendar year basis. Since it would be subject to the application of the provision for its cost reporting period beginning with January 1, 1974, it would be permitted to accumulate any unreimbursed costs (excess of costs over its charges) incurred during this reporting period. Since this cost reporting period ends before the end of the third year of operation, its carryover period will be the succeeding five cost reporting periods ending with December 31, 1979. Had this provider begun its operations on July 1, 1973, and become a participating provider as of the same date (with a fiscal year ending June 30), it would have been able to accumulate any unreimbursed costs for the two cost reporting periods ending June 30, 1975, and June 30, 1976. Its carryover period would then be the five cost reporting periods ending no later than June 30, 1981, in the case of costs unreimbursed in either of the reporting periods ending June 30, 1975, and June 30, 1976.

(ii) *New provider base period; unreimbursed costs under lower of cost or charges*. Where costs of a new provider are unreimbursed under this section but no costs are unreimbursed under § 405.460 during the new provider base period, such previously unreimbursed amounts which a provider may recover during any cost reporting period in the new provider base period or carry forward period is limited to the amount by which the aggregate customary charges applicable to health insurance beneficiaries during any such period exceed the aggregate costs applicable to such beneficiaries during that period, without regard to the application of the cost limits described in § 405.460(d) during the recovery period; except that no recovery may be made in any period in which costs are unreimbursed under § 405.460.

(iii) *New provider base period; unreimbursed costs under lower of cost or charges and cost limits*. Where costs of a new provider are unreimbursed under both this section and § 405.460 during the base period, such previously unreimbursed amounts carried forward shall be reimbursed to the provider in accordance with § 405.460(g)(3)(ii).

(e) *Public providers*. Fair compensation to public providers rendering services free of charge or at nominal charges, as defined in paragraph (b)(4) of this section, for the services they furnish will be the reasonable costs of covered services, as defined in this subpart.

.01 *Source:*

As adopted, 39 F. R. 16882 (May 10, 1974), and amended at 39 F. R. 20164 (June 6, 1974, effective July 1, 1974).

1972 AMENDMENTS
Medicare and Medicaid

[§ 18,992] Regulation Sec. 405.460. Limitations on coverage of costs.—

(a) *Principle.* In the determination of the allowability of provider costs, costs estimated to be in excess of those necessary in the efficient delivery of needed health services are excluded. Such estimates may be made with respect to direct or indirect overall costs or costs of specific items or services, or groups of items or services and upon publication in the FEDERAL REGISTER will constitute limits on amounts otherwise payable under the program. These limits will be imposed prospectively and may be on a per diem, per visit, or other basis.

(b) *Application.* In determining the limits to be applied, providers may be classified by type of provider (e. g., hospitals, skilled nursing facilities, and home health agencies) and within each provider class by such factors as the Secretary shall find appropriate and practical, such as:

- (1) Type of services rendered;
- (2) Geographical area where services are rendered, allowing for grouping of noncontiguous areas having similar demographic and economic characteristics;
- (3) Size of institution;
- (4) Nature and mix of services rendered; or
- (5) Type and mix of patients treated.

(c) *Data.* In establishing limits, the estimates of the costs necessary for efficient delivery of health services may be based on cost reports or other data providing indicators of current costs, with current and past period data being adjusted to arrive at estimated costs for the prospective periods to which limits shall be applied.

(d) *Notice of limits to be imposed.* Prior to the onset of a cost period to which a limit shall be applied, a notice shall be published in the Federal Register establishing the limits to be applied to an identified cost and type and class of provider of service.

(e) *Provider rights to review.* A request by a provider for review of the determination of an intermediary concerning classification for, exceptions to, or exemptions from the cost limits imposed under the provisions of this section shall be made to the intermediary under the provisions of Subpart R of this Part 405.

(f) *Exceptions, exemptions, and adjustments.* The following types of exceptions, exemptions, and classification adjustments may be granted under this section but only upon the provider's demonstration that the conditions indicated are present:

(1) *Reclassification.* A provider shall be entitled to obtain adjustment of its classification by the intermediary for the purpose of cost limits applied under this section on the basis of evidence that such a classification is at variance with the criteria specified in promulgating limits under paragraph (d) of this section.

(2) *Exception of cost of atypical services.* Where the actual cost of items or services furnished by a provider exceeds the applicable limit by reason of the provision of items or services that are atypical in nature and scope as compared to the services generally provided by institutions similarly classified and appropriate reason exists for the provision of such items or services, the limits may be adjusted upward to reflect any added costs flowing from the delivery of such items or services. Such adjustments may only be made where the provider demonstrates: (i) The provision of the atypical items or services were by reason of the special needs of the patients treated and necessary in the efficient delivery of needed health care, or (ii) the added costs flow from approved educational activities (as described in § 405.421) to the extent such costs are

§ 18,992 Reg. § 405.460

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atypical (although reasonable) for providers in the comparison group. In addition, such adjustments may be made only to the extent that such justified costs are separately identified by the provider and can be verified by the intermediary.

(3) *Exception because of extraordinary circumstances.* Where a provider's costs exceed the limits due to extraordinary circumstances beyond the control of the provider, the provider may request an exception from the cost limits to the extent that the provider shows such higher costs result from the extraordinary circumstances. These circumstances may include but are not limited to increased costs attributable to strikes, fire, earthquake, flood, or similar unusual occurrences with substantial cost effects.

(4) *Exemption as sole community provider.* The limitation on costs imposed under this section shall not be applicable where a provider by reason of factors such as isolated location or absence of other providers of the same type, is the sole source of such care reasonably available to beneficiaries.

(g) *New providers; accumulation of unreimbursed costs and carryover to subsequent periods—*(1) *General.* A new provider of services may carry forward for five succeeding cost reporting periods costs attributable to health insurance program beneficiaries which are unreimbursed under this section and not charged to patients during any cost reporting period ending on or before the last day of its third year of operation. Such period is called the new provider base period. If the five succeeding cost reporting periods combined include fewer than 60 full calendar months, the provider may carry forward such unreimbursed costs for one additional reporting period.

Example. A provider begins operation on April 7, 1973. However, it begins to participate in the health insurance program as of January 1, 1974, and reports on a calendar year basis. The provider would be permitted to accumulate any costs unreimbursed under this section which were incurred during reporting periods ending prior to April 7, 1976. Because the calendar year 1975 cost reporting period ends before the end of the third year of operation, its carryover period will be the succeeding five cost reporting periods ending on December 31, 1980. Had this provider begun its operations on July 1, 1973, and become a participating provider as of the same date (with a fiscal year ending June 30), it would have been able to accumulate any such unreimbursed costs for the cost reporting periods ending June 30, 1975, and June 30, 1976 (the limits are not applicable to the year ending June 30, 1974). Its carryover period would then be the five cost reporting periods ending no later than June 30, 1981, in the case of costs unreimbursed in either of the reporting periods ending June 30, 1975, or June 30, 1976.

(2) *New provider defined.* A new provider is an institution that has operated as the type of facility (or the equivalent thereof) for which it is certified in the program under present and previous ownership for less than 3 full years.

(3) *Recovery of unreimbursed excess cost—*(i) *New provider base period; unreimbursed costs under cost limits.* Where costs of a new provider are unreimbursed under this section during the new provider base period, but no costs are unreimbursed under § 405.455 during such base period, such unreimbursed amounts which a provider may recover during any cost reporting period in the new provider base period or carry forward period is limited to the lesser of (A) the amount by which the provider's current cost limit under this section exceeds the provider's reasonable cost for items and services to which such limit is applied during that cost reporting period, or (B) the amount by which the aggregate customary charges applicable to health insurance program beneficiaries during any such period exceeds the aggregate costs

for such services which are applicable to such beneficiaries during that period (see § 405.455).

(ii) *New provider base period; unreimbursed costs under lower of cost or charges and cost limits.* Where costs of a new provider are unreimbursed under the provisions of both this section and § 405.455 during the new provider base period, the amount of such unreimbursed costs which a new provider may recover during any cost reporting period in which the cost limit is not exceeded is limited to the extent that such unreimbursed costs plus normally reimbursable costs do not exceed aggregate customary charges with respect to health insurance beneficiaries during that period. In the application of this paragraph, costs previously unreimbursed under this section will be recovered first, in accordance with paragraph (g)(3)(i) of this section, and any remaining unreimbursed costs shall be carried forward to the next succeeding year within the new provider base period or carry forward period. Costs previously unreimbursed under § 405.455 may thereafter be recovered to the extent that aggregate customary charges with respect to health insurance beneficiaries exceed the aggregate reimbursable costs applicable to such beneficiaries plus amounts recovered under paragraph (g)(3)(i) of this section during that period. Any remaining unreimbursed costs under § 405.455 may be carried forward to the next succeeding reporting period within the new provider base period or carry forward period.

.01 Source:

As adopted, 39 F. R. 20164 (June 6, 1974, effective July 1, 1974), and at 40 F. R. 32742 (Aug. 4, 1975, effective with respect

to all capital expenditures, the obligation for which is incurred after 1972, or after the effective date of the agreement between the State and the Secretary, whichever is later).

→ **Caution:** For the Schedule of Limits in effect for cost reporting periods beginning after June 1975, see the material beginning on page 7901-12.

Schedule of Limits on Hospital Inpatient General Routine Service Costs
(For Cost Reporting Periods Beginning After June 1974 and Before July 1975)

[Pursuant to Reg. § 405.460, above, the following notice and "Schedule of Limits on Hospital Inpatient General Routine Service Costs" was published in the FEDERAL REGISTER (39 F. R. 20168, June 6, 1974):]

Notice is hereby given that the Schedule of Limits on Hospital Inpatient General Routine Service Costs in the Medicare program has been established by the Commissioner of Social Security, with the approval of the Secretary of Health, Education, and Welfare. This interim schedule is applicable for cost reporting periods beginning on or after July 1, 1974, and before the earlier of July 1, 1975 or the effective date of any revised schedule. The schedule set forth herein will be carefully reviewed by the Commissioner in the coming months with a view toward developing a more refined classification system which better adjusts for such cost factors as patient mix, scope-of-services, and the economic conditions of the local labor market. As revised, a new schedule will be published, with the approval of the Secretary, to be effective for cost reporting periods beginning no later than July 1, 1975.

¶ 18,992 Reg. § 405.460

The Schedule of Limits on Hospital Inpatient General Routine Service Costs set out below will apply to the entire cost reporting period of a provider whose cost reporting period begins during the effective period of this schedule. The schedule, as approved, applies to the total of the cost of routine services as defined in 20 CFR, § 405.452(d)(2) (also see § 405.452(d)(7)) and the inpatient routine nursing salary cost differential payment described in § 405.430. These limits do not apply to the cost of special care units or ancillary services. Section 1861(v)(1) of the Social Security Act as amended by section 223 (Limitations on Coverage of Costs Under Medicare) of P. L. 92-603 (the Social Security Amendments of 1972) permits the Secretary to set prospective limits on overall provider costs or provider costs for specific items or services based on estimates of the costs necessary in the efficient delivery of needed health services. Separate schedules of limits will be issued for skilled nursing facilities and home health agencies prior to the beginning of the cost reporting period to which such limits would be applied.

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Medicare Provider Reimbursement Manual §2103
(Prudent Buyer)

include, for example, costs of meals sold to visitors or employees; costs of drugs sold to other than patients; cost of operation of a gift shop; and similar items.

.14 Cafeteria costs.—The General Accounting Office reviewed Medicare payments made to 14 hospitals in five states by five intermediaries involving cost reports for the years 1968-1970. Although most of the payments were found to be correct, the GAO questioned, among other things, the failure to exclude indirect cafeteria expenses from Medicare costs.

Comp. Gen. Report, Aug. 3, 1972, "Problems Associated with Reimbursements to Hospitals for Services Furnished Under Medicare." [This Report originally appeared at NEW DEVELOPMENTS ¶ 26,497.]

.17 Chain operations.—Home office costs that are not otherwise allowable costs when incurred directly by the provider are not allowable as home office costs to be allocated to providers in a chain operation. See ¶ 5999V-2.

.21 Corporate costs.—Certain corporate costs—"stockholder servicing costs" and reorganization costs—are not related to patient care and are not allowable. See ¶ 5994 and 5994A.

.65 Partly allowable costs.—When costs are partly related to patient care and allowable, and partly not related to patient care and therefore not allowable, they are included among the annotations at ¶ 5862, above.

.72 Private printing of billing forms.—If a hospital or extended care facility wishes to have its own pinfeed versions of forms SSA-1453 and SSA-1483 printed at its expense, the proposed form should be approved by the Bureau of Health Insurance, Division of Systems, before the provider is authorized by the intermediary to print its own forms. Even if they obtain approval, providers will not be reimbursed by the Medicare program for printing costs.

I. L., No. 307 [Caution: Although this I. L. appears to still be valid, it has been declared obsolete by BHL]

.80 Provider's pay scale less than going rate; difference in salaries as allowable cost with respect to value of services of nonpaid workers.—See ¶ 5493.50.

[¶ 5868] PRUDENT BUYER (Prov. Reimb. Manual § 2103)

A. *General*.—The prudent and cost-conscious buyer not only refuses to pay more than the going price for an item or service, he also seeks to economize by minimizing cost. This is especially so when the buyer is an institution or organization which makes bulk purchases and can, therefore, often gain discounts because of the size of its purchases. It is quite common that discounts are given in these instances. In addition, bulk purchase of items or services often gives the buyer leverage in bargaining with suppliers for other items or services. Any alert and cost-conscious buyer seeks such advantages, [and] it is to be expected that Medicare providers of services will also seek them.

B. *Application of Prudent Buyer Principle*.—Intermediaries may employ various means for detecting and investigating situations in which costs seem excessive. Included may be such techniques as comparing the prices paid by providers to the prices paid for similar items or services by comparable purchasers, spotchecking, and querying providers about indirect, as well as direct, discounts. In addition, where a group of institutions has a joint purchasing arrangement which seems to result in participating members getting lower prices because of the advantages gained from bulk purchasing, any potentially eligible providers in the area which do not participate in the group may be called upon to justify any higher prices paid. Also, when most of the costs of a service are reimbursed by Medicare (for a home health agency which treats only Medicare beneficiaries, for example), the costs should be examined with particular care. In those cases where an intermediary notes that a provider pays more than the going price for a supply or service, in the absence of clear justification for the premium, the intermediary will exclude excess costs in determining allowable costs under Medicare.

C. *Examples of Application of the Prudent Buyer Principle*.—

1. Provider A consistently purchases supplies from supplier R and makes no effort to obtain the most advantageous price for its supplies. Supplier W sells identical or equivalent supplies at a lower cost and is also convenient to A. Unless the provider can clearly justify its practice of purchasing supplies from R rather than W, the intermediary should exclude any excess of R's charges over W's charges.

2. Supplier L supplies drugs to skilled nursing facility B and "rents" space from B to store the drugs to be used there. The rental paid by L to B for the space would generally constitute an indirect discount on the cost of drugs and must be reflected as a reduction of the cost of drugs supplied.

3. Dr. C, a hospital-based radiologist, purchases radiology equipment which he then leases to the provider where he is a staff member. Costs to the provider in this case are higher than if the equipment had been leased through competitive bidding from an outside source. The intermediary should reimburse the provider only for those costs which a prudent and cost-conscious buyer would pay and, therefore, those costs which the provider pays for the equipment leased from the staff radiologist which are in excess of costs for equivalent equipment obtained through competitive bidding should be denied.

.09 Chain operations.—Costs of a chain provider (including any allowable home office costs) are not recognized or allowed to the extent they are found to be out of line with similar institutions in the same area. See ¶ 5999V-3.

.15 Detection and investigation of situations involving excessive costs.—As discussed in § 2103 of the *Provider Reimbursement Manual* [above], it is expected that a provider of service, like any prudent and cost-conscious buyer, will not only refuse to pay more than the going price for an item or service, but also will seek to economize by minimizing cost. Where a provider chooses to pay above the going prices for an item or service, in the absence of clear evidence that the higher costs were unavoidable, the intermediary will exclude excess costs in determining allowable costs under Medicare.

In order to determine whether the provider is paying more than the going price, intermediaries may employ various means for detecting and investigating situations in which costs seem excessive. They may include such techniques as comparing the prices paid by providers with the prices paid for similar items or services by comparable purchasers, and spotchecking and querying the provider about indirect as well as direct discounts. In addition, where a group of institutions has a joint purchasing arrangement which seems to result in participating members getting very favorable prices because of the advantages gained from bulk purchasing, any potentially eligible providers in the area which do not participate in the group should be required to justify any higher prices paid.

The application of this concept by intermediaries does not envision that intermediaries will spend audit funds routinely in attempts to locate situations where a provider may have failed to act prudently in one or more aspects of its business operations or transactions. Rather, it intends that intermediaries be alert, from their professional contact with providers and their cost report settlement process, to situations where a provider's costs of operations will become or in fact already are out of line (i.e.,

appear unreasonable) with similar costs of comparable providers. Where such situations are noted, the Medicare program expects the intermediary to evaluate the out of line cost, using all appropriate methods available, one of which would be an evaluation of the management practices of the provider that contributed to the incurrence of the excess cost. If it is determined by this effort that the cost is out of line with what comparable providers incur because the provider, among other things, failed to act prudently when incurring the cost, that portion of the cost which exceeds what comparable providers incurred constitutes unreasonable costs not reimbursable by Medicare.

Part A Intermediary Manual, HIM-13 (Part 2), § 2130.1.

.63 Reimbursement of claims involving excess costs.—The fact that a provider has paid more than the going rate for an item or service because he is unaware of alternative sources of supply or of the discounts available in his area does not of itself justify waiving the "prudent buyer" rule. In cases where the intermediary finds that judgments about the "going price" for an item or service might reasonably differ, the intermediary may reimburse the provider for the costs it incurred. In such cases, the intermediary shall send and maintain a record of a written notice to the provider that the costs involved are out of line and that similar costs will be disallowed in the future.

Where excessive costs result from purchases made to secure a financial or other advantage for the provider or made knowingly in disregard of cost considerations, any reimbursement which may have been made in excess of those costs determined to be reasonable constitutes an overpayment. Intermediaries shall notify the provider of such overpayment and begin immediately to recover the excess amount.

Part A Intermediary Manual, HIM-13 (Part 2), § 2130.3

.67 Situations requiring close scrutiny by intermediary.—Wherever there are dealings between ostensibly unrelated providers and suppliers, but where there is reason to sus-

pect that there is, in fact, a financial relationship between the two, intermediaries shall examine costs purportedly incurred with special care to assure that all direct and indirect discounts were reflected in determining costs. Where, for example, a supplier of drugs "rents" space from a skilled nursing facility to store drugs for use in the facility, the rental paid by the supplier to the provider would generally constitute an indirect discount on the cost of drugs which must be reflected as a reduction of the cost of drugs supplied.

Also, when most or all of the recipients of a service are Medicare beneficiaries,

costs incurred should be examined with particular care to ensure that the providers are motivated to seek discounts or exercise prudence to the degree they otherwise would. Particular attention should be given to situations where a provider contracts with an outside supplier to render various services. The intermediary should determine whether it would have been feasible for the provider to provide the services more economically by hiring additional personnel on a part-time or full-time basis.

Part A Intermediary Manual, HIM-13 (Part 2), § 2130.2

→ *Caution: The following section of the Prov. Reimb. Manual has not been revised to reflect the regulations limiting the amount of reimbursement allowed for prescription drugs effective April 26, 1976. See ¶ 18,965 and 21,195B.*

[¶ 5869] Cost of Drugs and Related Medical Supplies (Prov. Reimb. Man., Part I, § 2103.1)

A. *General.*—The cost of drugs and related medical supplies furnished by providers to Medicare beneficiaries are reimbursable by the program on a reasonable cost basis. To meet the test of reasonableness, the cost of the drug or medical supply should not exceed the amount a prudent and cost-conscious buyer would pay for the same item.

B. *Prescription Drugs.*—Providers which have their own pharmacy are expected to purchase drugs in bulk, where possible, from manufacturers or recognized wholesale outlets to gain economies from quantity purchasing.

Providers not having their own pharmacies generally purchase drugs under arrangements with local pharmacies rather than from manufacturers or wholesalers. Where the drugs are purchased under arrangements, the charges to the provider by the supplier become the provider's pharmacy costs. In such cases, these providers should pay no more than the going rate for prescription drugs and, in addition, should seek to minimize their pharmacy costs by obtaining discounts, either direct or indirect, from the supplier. It is not expected that a provider will utilize the services of a higher charge pharmacy for its normal prescription needs merely because the pharmacy provides 24-hour emergency services. Of course, the Medicare program will recognize the costs of services from a pharmacy furnishing 24-hour services when a prescription is required at a time when the provider's normal source of prescription is not available, even though this pharmacy may have higher charges than and may not be the same as the one with which the regular prescription orders are placed.

A pharmacist's fee for consultant services should not be included in the price of the prescriptions. If the extent of the consultant services is such that the pharmacist believes it necessary to make a charge for these services, then it would be appropriate for the pharmacist to make a separate charge to the provider. The charge for the consultant services may be included in the provider's administrative costs, to the extent reasonable. The provider should document the extent of these services received so that any payment for them may be evaluated under the prudent buyer policy. It is recognized, however, that in many cases it would not be reasonable to charge the provider for the services, since the pharmacist already receives compensating value in the volume of prescription business done under the arrangement with the provider.

The provider, as part of its financial recordkeeping responsibility under the program, must have on supplier invoices all needed cost verification information—i.e., name, brand, quantity, form and strength of the drugs supplied and the

8.

Décision in Kaye v. Whalen (Sup. Ct. Albany Co.
September, 1976)

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SUPREME COURT OF THE STATE OF NEW YORK

COUNTY OF ALBANY

LESLIE KAYE, BARUCH GLOBERMAN, and SOL MALLOW,
as Operators of the SANS SOUCI NURSING HOME;
EMMANUEL BIRNEAUM and DESDEMONA JONES, as
Operators of the FLELDSTON LODGE NURSING
HOME; AND THE NEW YORK STATE HEALTH FACILITIES
ASSOCIATION, a New York not-for-profit member-
ship corporation, suing on behalf of its member
licensed nursing homes and health-related
facilities located within the State of
New York,

Petitioners,

against

ROBERT P. WHALEN, as Commissioner of Health of
The State of New York, and PETER C. GOLDBARK, as
Director of the Budget of the State of New York,

Respondents.

For a Judgment Pursuant to Article 78 of the
Civil Practice Law and Rules

Supreme Court, Albany County Special Term, February 27, 1975
Calendar #16

JUSTICE ELLIS J. STALEY, JR., PRESIDING

APPEARANCES:

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Arthur A. Patana, Esq. of Counsel

This is a proceeding pursuant to CPLR, article 73, for a judgment compelling the respondents to establish medical reimbursement rates in accordance with section 2807 of the Public Health Law, and the regulations promulgated by the Commissioner of Health, and to apply such rates retroactively to January 1, 1975.

Petitioners represent, as a class, all nursing homes and health related facilities in the State of New York participating in the Medicaid Program, which program is a joint Federal State grant-in-aid program with the Federal government contributing 50 per cent of the funds, the State 25 per cent and the county 25 per cent. The Federal funds are distributed to the State where they are combined with funds appropriated by the State and its subdivisions. These funds are then paid by the State to the nursing homes and health related facilities rendering services to eligible Medicaid recipients. In New York State, the payments are made pursuant to rates established by the Commissioner of Health pursuant to section 2807 of the Public Health Law, which statute, in addition to setting forth certain factors which the Commissioner is to take into consideration in establishing rates, provides that "The Commissioner shall notify each hospital and health related service of its approved rate at least 60 days prior to the fiscal year for which the rate is to become effective."

In determining the rates, the Commissioner is also required by section 2802(2) of the Public Health Law, effective August 6, 1975, to exclude certain enumerated costs. The State Hospital Review and Planning Council is directed by section 2893(2) of the Public Health Law to adopt and amend rules and

regulations subject to the approval of the Commissioner, to effectuate the provisions and purposes of article 28 of the Public Health Law including, but not limited to, the establishment by the department of schedules of rates, payments, reimbursements, grants and other charges for hospital, health related services, and home health services as provided in section 2807.

Section 2808 of the Public Health Law, charges the Commissioner with the responsibility of promulgating interim regulations to expire no later than December 31, 1976 that will relate the rate of payment for each residential health care facility to the operation and program management of the facility as well as to the quality of patient care provided by the facility, and to promulgate interim regulations regarding real property costs to expire on the same date which shall be applicable to all residential health care facilities. By definition the facilities operated by the petitioners are residential health care facilities. (Public Health Law, § 2801[3].)

The regulations provided to be promulgated by the statutes are to be found in 10 NYCRR, Part 86. For the most part, the regulations were amended and filed October 14, 1975, effective October 14, 1975. The new regulations for the most part do not affect residential health care facilities, pursuant to 10 NYCRR, 86.1 which excepts residential health care facilities from the definition of the term medical facility. Section 86.3 entitled Interim rules for residential health care facilities, provides as follows: "For the purposes of reporting and rate

certification for residential health care facilities, the provisions of this part, in effect on October 8, 1975, shall remain in effect for an interim period until regulations have been promulgated pursuant to sections 2807 and 2808 of the Public Health Law. The provisions of sections 86.15(b)(4), 86.17(a) and (b), and 86.21(k) of this part, filed with the Secretary of State on November 26, 1975, apply to residential health care facilities as of said date."

The provisions of section 86.10 of the regulations in effect on October 8, 1975, are as follows:

"Certification of reimbursement rates of payment by governmental agencies will be for a 12-month calendar year period. Certification of reimbursement rates by article IX-C corporations will be for the periods specified in the reimbursement formula approved by the Commissioner of Health."

By their petition, the petitioners assert that, in establishing the 1976 rates, the respondent Commissioner did not comply with the Statutory and regulatory procedures for calculating reimbursement rates, and simply froze the 1975 reimbursement rates. This contention is based upon the following factual allegations: On October 31, 1975, Hospital Memorandum, series 75-159 was issued stating that "each hospital, nursing home, health related facility, treatment or diagnostic center and home health agency has been directly notified of its Medical reimbursement rates for the period January 1, 1976 through December 31, 1976. The individual rates for each health facility were developed on an interim basis. New legislation concerning 1976 reimbursement, and still unresolved aspects of Part 86 of the Commissioner's rules have made it impossible to promulgate

final health facility rates at this time." The memorandum further stated that final rates reflecting either upward or downward revisions will be promulgated as soon as possible. The rates established were reaffirmed by Hospital Memorandums 76-6 and 76-7 dated January 9, 1976 wherein it was stated that "It is still not possible to promulgate final rates, so the rate schedules will be used to permit billings at the interim level."

The 1976 reimbursements rates established by the Commissioner are, according to petitioners, in all cases identical to or lower than the 1975 rates for all members of the class, whereas they should have been increased by reason of (1) increased labor costs mandated by pre-existing negotiated contracts or increased labor costs consistent with labor costs in the relevant geographical area, or increase in the Federal minimum wage; (2) higher allowable costs during the base period upon which 1975 rates would properly be calculated; (3) increases attributable to necessary additions to staff and services mandated by State and Federal regulations; (4) a projected cost increase factor which the Commissioner has calculated but not applied; and (5) other increased costs which would have been recognized had Part 86 of the Commissioner's Rules been followed.

The petitioners further contend that they and the other members of the class may not refuse to accept Medicaid patients (State Hospital Code, § 730.2[1]) and that, unless they receive the Medicaid rates to which they are entitled by statute and regulation, they will be unable to provide the mandated level of

services and care required by State and Federal regulations, thereby jeopardizing the health and safety of the patients, and thereby subjecting themselves to the severe penalties and fines amounting to as much as \$1,000.00 per day pursuant to section 2803(6) of the Public Health Law. The Medicaid population of these facilities are stated to be approximately 65 to 75 per cent.

The petitioners further contend that the actions of the respondents in establishing the 1976 Medicaid reimbursement rates at the 1975 level is illegal, arbitrary, capricious and unconstitutional.

As a second ground for relief, the petitioners assert that, although 10 NYCRR 86.17 provides for administrative appeals for redetermination of certified rates, the Commissioner will not entertain such appeals on the ground that they are interim rates, and they were not accompanied by rate calculation sheets. Evidence of this position is contained in a letter to the court for a member of the class dated November 24, 1975, signed by the Director of the Bureau of Health Care Reimbursement.

As a third ground for relief, the petitioners assert that any change in a State plan under the Medicaid Program effectuating a reduction of money payments requires the prior approval of the United States Secretary of Health, Education and Welfare, (42 USC, § 1396-a[c]) and respondents' actions in establishing the 1976 rates without such approval jeopardizes the entire State Medicaid Program by inviting its termination for noncompliance with the Federal requirements.

As a fourth ground for relief the petitioners assert

that under Federal law, State reimbursement for Medicaid must, after July 1, 1976, be made on a "reasonable cost related basis (42 USC, § 1396-a[a][12][E]), and that the arbitrary and capricious rates set by respondents without regard to costs and stated to be applicable for the entire year violate the specific provisions of the Federal Law, thereby jeopardizing the entire Medicaid Program in the State, and inviting termination for noncompliance pursuant to 42 USC, § 1396(c).

The petitioners ask for a judgment (1) declaring the actions of the respondents in establishing the 1976 rates illegal, null and void; (2) ordering the respondents to compute a reimbursement rate for each nursing home and health related facility for fiscal 1976 in accordance with the effective regulations and statutory requirements, and to apply such rates so computed retroactively to January 1, 1976; (3) enjoining respondents permanently from effectuating any amendments or changes in the method of reimbursement of nursing homes and health facilities in a manner not in compliance with the approved State Plan file with the United States Department of Health, Education and Welfare, without the prior approval of the Secretary of Health, Education and Welfare; and (4) enjoining respondents from effectuating any amendments in the method of such reimbursement for any period subsequent to July 1, 1976 which is not consistent with the reasonable cost related requirements of 42 USC, § 1396(a)(E).

The respondents' answer consists of a general denial of the material allegations of the petition; an allegation

that section 2808 of the Public Health Law supplants all or at least a portion of section 2807; an affirmative defense that fiscal conditions and statutory uncertainty made it necessary to certify and approve interim rates which is not arbitrary and capricious or contrary to statute or regulation; and an affirmative defense that petitioners have failed to set forth facts entitling them to the relief sought or to any relief pursuant to CPLR, article 78.

An affidavit attached to the answer by the respondent Commissioner recognizes the requirements of section 2807(4) of the Public Health Law as to notification of reimbursement rates 60 days before the fiscal year in which they are to be used. The affidavit further states that the Commissioner requested approval from the Director of the Budget to establish interim rates for 1976 on October 23, 1975, and that he received such approval based upon fiscal considerations and statutory approval. The affidavit then elaborates upon the financial plight of the City of New York, and the impact of the Medicaid Program upon the budget of the City of New York and of the State, and states that based upon the financial uncertainties facing both the City of New York and the State, it was neither prudent nor possible to develop the 1976 reimbursement rates for health care facilities without legislative budgetary guidance, which guidance was expected in a Medicaid bill anticipated to be passed by the Legislature by March 15, 1976. Reference is also made to section 2808 of the Public Health Law and its effect on rate setting provisions of sections 2807 and the anticipated Moreland Act Commission report which would probably recommend

further statutory revisions.

However commendable and cogent the reasons advanced by the Commissioner for establishing interim rates may be, for the purposes of financial stability and integrity, it is clear that the Commissioner has not followed statutory directives and his own rules and regulations. While section 2808 has a certain impact on rates, it required him as of its effective date to promulgate "interim regulations", not interim rates, for residential health care facilities. The Commissioner was aware of this when he promulgated rule 86.34 quoted above as an interim rule. Nowhere in the appropriate statutes, or in the rules and regulations is there found any authority to depart from statutory procedure or from the procedure established by the rules and regulations. A statute may not be disregarded on the speculation that it may be repealed or amended.

By his own affidavit, the Commissioner admits that he established interim rates in anticipation that the statutes relating to the reimbursement rates for residential health care facilities would be amended. The letter dated November 24, 1971 signed by the Director of the Bureau of Health Care Reimbursement makes it clear that the rates were not established according to statutory requirements, or according to the requirements of the rules and regulations in effect for that purpose, otherwise rate calculation sheets would have accompanied the established rates. The obvious purpose of such procedure was, of course, to foreclose the right of an administrative appeal, as authorized by section 2806(4) and rule 26.17 of the Public Health Law.

The obvious intent here was to assist the City of New York and the State in a time of fiscal crisis. The effect was to deprive the petitioners and the members of the class of income to which they were entitled according to statute and rule. While there exists a strong presumption of reasonableness as to the Commissioner's decision, the obvious disregard herein of statutes and regulations overcomes that presumption. The case of Matter of Sigety v. Ingraham (29 N Y 2d 110) cited as the authority of the Commissioner to limit the reimbursement rate is not in point. In that case, there was a statutory and regulatory basis for the action of the Commissioner which is not evident here.

The petition also alleges a violation of the Federal statutes affecting the Medicaid Program. While the answer generally denies these allegations, the Commissioner's affidavit and the respondents' brief fail to respond to these allegations, thus no attempt is made to establish compliance with the Federal statutes, or to establish that the approval of the Secretary of Health, Education and Welfare is not required for the procedure adopted herein. Under the circumstances, it must be assumed that the respondents have also violated the Federal statutes.

Subsequent to the commencement of this proceeding, the Legislature amended the Public Health Law by the enactment of Chapter 76 of the Laws of 1976. Section 11 of chapter 76 amended subdivision 2 of section 2807 by adding certain subsections thereto.

Section 2(e) provides:

"During the period beginning January first, nineteen hundred seventy-six, and ending March thirty-first, nineteen hundred seventy-seven, the commissioner may determine and certify to the director of the budget rates of payment for residential health care facilities without regard

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advisable
highly
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advisable

to the provisions of subdivision three of this section. The commissioner is directed to formulate such rates in accordance with the provisions of paragraph c of subdivision one of section twenty-eight hundred three and section twenty-eight hundred eight of this chapter which rates shall be effective for the period hereinbefore specified in this paragraph notwithstanding any inconsistent provision of such section twenty-eight hundred eight."

Section 13 of chapter 76 provides that this section "shall be deemed to have been in full force and effect on and after the first day of January, nineteen hundred seventy-six."

Section 13 of chapter 76 adds a new subdivision 4 to section 2807 which provides as follows:

*new 60 day
notice
requirement*

"The commissioner shall notify each hospital and health related service of its approved rate at least sixty days prior to the beginning of an established rate period for which the rate is to become effective."

Section 16 of chapter 76 provides as follows:

*remains
60 day notice
requirement
suspended*

"The effectiveness of the provisions of subdivision four of section twenty-eight hundred seven of the public health law, as added by chapter six hundred eighty-two of the laws of nineteen hundred seventy-four, are hereby suspended and shall, for all purposes whatsoever, be deemed to have been without any force or effect from and after November first, nineteen hundred seventy-five."

Section 13 of chapter 76 provides that sections 13 and 16 shall take effect immediately, provided, however, that they shall remain effective only to and including March 31, 1977; and "shall be thereafter effective only in respect to any act done on or before such date or action or proceeding arising out of such act."

Section 18 also provides as follows:

"The state commissioners of health, social services and education shall, prior to such effective dates, take all necessary steps to inform providers and recipients of medical assistance of the provisions of this act and are authorized to take such other steps as may be necessary to effectuate the purposes of this act. This act shall apply to care, services and supplies furnished on and after the applicable effective date. This act shall not be construed to alter, change affect, impair

or defeat any rights, obligations, duties or interests accrued, incurred or conferred prior to the enactment of this act, nor shall this act be interpreted so as to deny care, services or supplies to any individual if such care, services and supplies are necessary in order to complete a course of treatment initiated prior to the enactment of this act."

Chapter 76 was approved by the Governor on March 30, 1976.

Section 2803(1)(c) of the Public Health Law charges the Commissioner with the duty of promulgating and publishing uniform criteria for the evaluation of residential health care facilities with respect to their compliance with the standards set forth in section 2803 based upon inspections. It also provides that the Commissioner shall devise a rating system consisting of no less than five specific rating categories, the ratings to be based upon inspections. Section 2808 requires the promulgation of regulations which tie the reimbursement rates to the ratings established pursuant to section 2803(1)(c).

At the time of the commencement of this proceeding, the Commissioner had not implemented section 2803(1)(c) or section 2808 except insofar as section 86.34 of the Commissioner's regulations continued the regulations for rate certification in effect on October 8, 1975, until regulations had been promulgated pursuant to sections 2807 and 2808.

The Commissioner now asserts that section 16 of Chapter 76 of the Laws of 1976 effectively eliminated the specific time framework in which the Commissioner had in which to certify new reimbursement rates, and that new reimbursement rates to be published on August 1, 1976, retroactive to January 1, 1976, render the issue raised in the petition moot. Such is not the case. The suspension of subdivision 4 of section 2803 by section 16 of Chapter 76 of

the Laws of 1976 merely gives the Commissioner absolution for his violation of that section. It does not absolve him of the duty of establishing proper rates in accordance with contractual obligations, statutes and regulations under which the Commissioner had no authority to freeze the rates at 1975 levels.

The Court has not been apprised as to whether the new reimbursement rates were actually published on August 1, 1976, or of the basis upon which such rates were determined, if published. While the Commissioner asserts such new rates were to be published on August 1, 1976, he does not assert that he has complied with the requirements of section 2803 (1) (c) by promulgating and publishing uniform criteria for evaluation of health related facilities, and by devising a rating system for such facilities. He also does not assert that he has promulgated regulations pursuant to section 2803 different than those in effect on October 8, 1975. In the absence of such implementation of these statutes, there is no basis upon which the Commissioner could publish new reimbursement rates other than upon the statutes and regulations in effect on January 1, 1976 prior to the enactment of Chapter 76 of the Laws of 1976.

There exists a further reason why the Commissioner must establish reimbursement rates based upon the statutes and regulations existing on January 1, 1976. Medicaid services are provided by nursing homes pursuant to Provider Agreements between the nursing homes and the State which provide for reimbursement at a rate established by law. The regulations in effect on January 1, 1976 (section 86.10 hereinbefore set forth) provided for certification of reimbursement rates for a twelve month calendar year period, a

section 2007(4) required notification of the approved rates at least 60 days prior to the beginning of an established rate period. These provider agreements are contracts establishing the rights, duties and obligations of the parties. While the State as the sovereign has the power to enact new laws, it cannot do so in a manner to unilaterally amend its own contracts for its own benefit. Further, section 18 of Chapter 76 of the Laws of 1976 provides:

"This act shall not be construed to alter, change, affect, impair or defeat any rights, obligations, duties or interests accrued, incurred or conferred prior to the enactment of this act * * * *."

The provisions of chapter 76 cannot, therefore, be applied retroactively so as to defeat or impair the rights, obligations and duties of the parties to these provider agreements which had accrued prior to the enactment of chapter 76.

Judgement is, therefore, awarded to the petitioners, and the members of the class for the relief sought in the petition.

Attorneys for petitioners to submit order and judgment.

All papers to the attorneys for petitioners for filing upon entry of the order herein.

Date: September

9.

Decision in Kaye v. Whalen (App. Div. 3d Dept.
February 14, 1977)

HANDED DOWN

February 14, 1977.

29801

In the Matter of LESLIE KAYE et al.,
on Behalf of Themselves and All
Others Similarly Situated, Respondents,
v.

ROBERT P. WHALEN, as Commissioner of
Health, et al., Appellants.

Judgment reversed, on the law and the facts, and petition dismissed, without costs. Upon service of a copy of the order to be entered hereon together with notice of entry, the preliminary injunction heretofore granted by order of this court, entered November 19, 1976, is vacated.

Opinion per MAHONEY, J.

LARKIN and HERLIHY, JJ., concur; KANE, J. P., and MAIN, J., dissent and vote to affirm in an opinion by KANE, J. P.

STATE OF NEW YORK

SUPREME COURT

APPELLATE DIVISION

THIRD DEPARTMENT

In the Matter of LESLIE KAYE
et al., on Behalf of Themselves
and All Others Similarly Situated,

Respondents,

-against-

ROBERT P. WHALEN, as Commissioner
of Health, et al.,

Appellants.

Argued, November 23, 1976.

Before:

HON. T. PAUL KANE,

Justice Presiding,

HON. A. FRANKLIN MAHONEY,

HON. ROBERT G. MAIN,

HON. JOHN L. LARKIN,

HON. J. CLARENCE HERLIHY,

Associate Justices.

APPEAL from a judgment of the Supreme Court at Special Term
(Ellis J. Staley, Jr., J.), entered September 16, 1976 in Albany
County, which granted petitioners' application in a proceeding pursuant
to CPLR article 78.

LOUIS J. LEFKOWITZ, Attorney-General (Arthur Patane and Ruth
Tessler Toch of counsel), for appellants, The Capitol, Albany, New York
12224.

O'CONNELL & ARONOWITZ, P.C. (Cornelius D. Murray of counsel), for
respondents, 100 State Street, Albany, New York 12207.

OPINION FOR REVERSAL

MAHONEY, J.

The Medicaid Program (Subchapter XIX of the Social Security Act, U.S. Code tit. 42, § 1396 et seq.) makes available funds, to be supplemented by State contributions, to pay for the medical care of those whose means fall below certain financial standards. The federal funds are available to those States which submit a plan for administering the funds acceptable to the Secretary of Health, Education and Welfare (U.S. Code tit. 42, § 1396). The statute imposes myriad requirements as to what constitutes an acceptable plan (U.S. Code tit. 42, § 1396a), but does not purport to set the specific rates at which those providing the medical services are to be reimbursed. That duty is left, within the confines of the requirements of section 1396a, to the States.

The New York State Legislature charges the respondent Commissioner of Health with the responsibility of setting the rate at which the petitioners, nursing home owners, are reimbursed for the care they provide Medicaid beneficiaries. Until August, 1975 the statutory standard by which the Commissioner was directed to set rates was subdivision 3 of section 2807 of the Public Health Law, which required that the rates be "reasonably related to the costs of efficient production of such service." The subsection goes on to impose a few specific standards, such as requiring the Commissioner to consider "geographical differentials in the elements of cost" and to "exclude costs for research." Subdivision 4 of section 2807 (L. 1974, ch. 682, § 1) directs the Commissioner to notify each nursing home of new rates 60 days before the fiscal year for which the rates are to be effective.

The Commissioner promulgated regulations, as he was required to do (Public Health Law, § 2803, subd. [2], par. [b]), stating in detail the criteria by which he would set the reimbursement rates (10 NYCRR, Part 86). The regulations also specified that the rates would be set for calendar year periods (10 NYCRR 86-1.10). Thus, it appears from both the regulations (10 NYCRR 86-1.10) and the statute (Public Health Law, § 2807, subd. [4]) that new rates would be established before November 1 each year, to become effective the following January 1 and remain in effect for one year.

This case concerns the legality of two actions by the Commissioner. In November, 1975 he adopted as tentative rates for 1976 the 1975 reimbursement rates, rather than generating new rates based on the criteria set forth in the then-existing Department regulations. In October, 1976 he established new rates and made them retroactive to

January 1, 1976, thereby supplanting the tentative rates set the previous November. Petitioners, nursing home owners, brought this article 78 proceeding in February, 1976 to invalidate the tentative rates of November, 1975 and to force the Commissioner to set 1976 rates consistent with his 1975 regulations. In September, 1976 Special Term granted the requested relief and further enjoined the Commissioner from changing his method of computing rates without first securing the approval of the U.S. Department of HEW. Although the Commissioner's rate-setting action of October, 1976 occurred after Special Term's judgment, the substance of the post-judgment rate-setting is not disputed and may be considered here without the need to remand. We accept the truth of petitioners' uncontested allegation that both the November, 1975 and October, 1976 rates for 1976 are generally lower than the 1976 rates would have been had they been set in keeping with the regulations.

Petitioners' first ground for relief is that in each instance the Commissioner acted without statutory authorization. With respect to the November, 1975 tentative rates, it is true that the then-existing regulations stated criteria, established under the standards of subdivision 3 of section 2807 of the Public Health Law whereby rates would be set for each new calendar year. Absent further legislative action before January 1, 1976, perhaps it would be fair to conclude that the Commissioner was bound either to promulgate new regulations in the manner required by law (see N.Y. Const., art. IV, § 8; Executive Law, §§ 102, 103, 105) or to mechanically generate new rates conforming to the extant regulations. (But see, State Administrative Procedure Act, § 202, subd. 1[d] [eff. Sept. 1, 1976].*)

However, further legislative action had been taken, with the addition of section 2808 (L. 1975, ch. 649, § 7, and ch. 650, § 2 [eff. Aug. 6, 1975]), which provided, inter alia, that:

* Section 202 of the SAPA makes explicit after September 1, 1976 what previously may have been implicit in the nature of the function of administrative agencies, to wit " * * * if the agency finds that immediate adoption * * * or repeal of a rule is necessary for * * * the public health, safety, or general welfare, and that observation of the requirements of notice and public hearing would be contrary to the public interest, the agency may dispense with all or part of such requirements and adopt the rule * * * or repeal as an emergency measure".

1. a. The Commissioner shall promulgate interim regulations to expire no later than the thirty-first day of December, nineteen hundred seventy-six, that will relate the rate of payment for each residential health care facility to the operation and program management of the facility, as well as to the quality of patient care provided by the facility. Such regulations shall be consistent with regulations promulgated under the provisions of title eighteen of the federal social security act, by which payment for costs incurred by a residential health care facility for a quantity and quality of supplies or services necessary for the proper operation of a residential health care facility shall not exceed those which would be paid in the normal course of business by a prudent buyer of such supplies or services. [Emphasis supplied.]

Paragraph (b) of subdivision 1 goes on to direct promulgation of interim regulations regarding real property costs. Section 2 mandates that certain costs, such as political or lobbying payments, certain types of advertising expenses, and fines should not be added in to determine 1976 rates.

Although certain aspects of section 2808, such as the provision disallowing consideration of fines paid, may have been implicitly part of the pre-existing statutory standards of subdivision (3) of section 2807 (under which the regulations existing in 1975 were promulgated), there were certainly some significant changes made by section 2808. The controlling standard for rate determination in subdivision (3) of section 2807 was that rates be "reasonably related to the costs of efficient production of such service." The general standard added August 6, 1975 by section 2808, as noted above, was that rates "shall not exceed those which would be paid in the normal course of business by a prudent buyer of such supplies or service." Moreover, section 2808 incorporated new, detailed standards via regulations under the federal social securities act.

For the Commissioner to ignore the new standards of section 2808 by simply generating new rates through his old regulations would have been clearly in conflict with the Legislature's will. Surely, the Legislature cannot be encumbered, absent constitutional constraints, by the administrative delays involved in promulgating new regulations. The purpose of regulations is to carry out statutory directives. It is

true section 2808 required promulgation of interim regulations, but apparently the Commissioner had insufficient time between August 6 and November 1, 1975 to do so. It was better to carry out the substantive standards of section 2808 by tentatively continuing (without interim regulations) the 1975 rate, believing it to closely approximate the rate mandated by section 2808, than to set a new rate on the basis of regulations promulgated under a statutory standard (§ 2807, subd. [3]) no longer in effect. Petitioners have not even attempted to prove that the interim rate set in 1975 was inconsistent with the standard of section 2808.

In any event, the Commissioner's November, 1975 action was mooted by the 1976 rates set on October 22, 1976. These rates, set pursuant to new regulations published contemporaneously with the new rates, are retroactive to January 1, 1976 and therefore will fully supplant the tentative rates. Retroactive application to January 1, 1976 of rates set pursuant to section 2808 (rather than the more generous standard of section 2807, subd. 3) was explicitly authorized by the addition of paragraph (e) of subdivision 2 of section 2807. - -

During the period beginning January first, nineteen hundred seventy-six, and ending March thirty-first, nineteen hundred seventy-seven, the commissioner may determine and certify to the director of the budget rates of payment for residential health care facilities without regard to the provisions of subdivision three of this section. The commissioner is directed to formulate such rates in accordance with the provisions of paragraph c of subdivision one of section twenty-eight hundred three and section twenty-eight hundred eight of this chapter which rates shall be effective for the period hereinbefore specified in this paragraph * * *.

(L. 1976, ch. 76, § 11 [enacted March 30, 1976].)

Petitioners contend that no retroactive application was intended since section 18 of chapter 76 of the Laws of 1976 stated "[t]his act shall apply to care, services, and supplies furnished on and after the applicable effective date." This presents no ambiguity since section 13 sets several different effective dates for different portions of chapter 76 and states that section 11 (i.e., the portion adding section 2807, subd. 2, par. [e]) "shall be deemed to have been in full force and effect on and after the first day of January, nineteen hundred seventy-six."

Aside from any question of statutory authorization, petitioners contend the Commissioner's actions impaired contractual rights. The only contract they claim rights under is the form agreement between each of them and the State, entitled "New York State Department of Social Services Medicaid Provider Agreement (Full Compliance)". By the terms of this agreement the particular nursing home is certified for 12 months as in full compliance with the federal standards for a "Skilled Nursing Home" (45 C.F.R., Part 249) and "in consideration of receiving payments for services provided to individuals receiving assistance under the New York State Plan * * * pursuant to [Medicaid] hereby agrees" to keep certain records and to "not discriminate as to source of payment in admission and retention of patients * * *".

Petitioners argue that this agreement incorporates all details of the New York State Plan which, in order to obtain federal medicaid funds, was submitted for HEW approval. Since that Plan included the Commissioner's 1975 regulations for generating reimbursement rates, there is an implicit promise by the State to the various participating nursing homes that payment would be made at rates consistent with those regulations. This interpretation does not follow from the contract language. The reference to the "New York State Plan" seems intended only to identify exactly which patients the contract covers. Petitioners allege no extrinsic facts which lead to a different construction. Although there may be an implicit promise by the State to retain the reimbursement rate at some minimum level, the contract is insufficiently precise to support petitioners' claim to a rate above that which the statute now authorizes; the statutory standard being an amount not to exceed that "which would be paid in the normal course of business by a prudent buyer of such supplies or services" (Public Health Law, § 2808, subd. 1, par. [a]; L. 1975, ch. 649, § 7). The Supreme Court of Minnesota, on facts very close to those herein, has similarly held a plaintiff nursing home which executed a federal "provider agreement" had no contractual right to any particular level of payment (LaCrescent Constant Care Center, Inc. v. State Department of Public Welfare, 301 Minn. 229, 222 N.W. 2d 87 [1974]).

Petitioners next contend that the respondent violated U.S. Code tit. 42, § 1396a [a] [13] [E] in not obtaining prior HEW approval for the new October, 1976 rates and regulations. Section 1396a imposes various requirements on the State plans for administering Medicaid funds. Subdivision (a) (13) (E) requires such plans to provide - -

effective July 1, 1976, for payment of the skilled nursing facility * * * services provided under the

plan on a reasonable cost related basis, as determined in accordance with methods and standards which shall be developed by the State on the basis of cost-finding methods approved and verified by the Secretary * * *. [Emphasis supplied.]

This statute was the basis for Special Term's order to respondent to continue reimbursement to petitioners at a rate consistent with the 1975 regulation until approval for new rate-making procedures is obtained from HEW.

Assuming petitioners have standing to enforce the approval requirement, the first issue is whether this statute, effective July 1, 1976, applies to a new rate-making procedure implemented in October, 1976 to be retroactive to January 1, 1976. The Department of HEW promulgated on July 1, 1976 a regulation pursuant to section 1396a (a) (13) (E) which exactly repeats the statutory language quoted above (45 C.F.R. 250.30 [a] [3], added by 41 Fed. Reg. 27305 [1976]). Respondent Commissioner has appended to his brief a letter dated September 30, 1976 from the Associate Regional Commissioner of HEW responding to a question posed by the New York Department of Social Services as to whether "there are any restrictions in terms of statutory or regulatory requirements to New York adopting a revised rate for [Nursing Homes] on a retroactive basis." The Associate Commissioner answered, inter alia, that

Prior to the publication of the July 1, 1976 regulation, there was no specific methodology of reimbursement required for [Nursing Homes] in the [Medicaid] State plan. The regulations * * * provided that the State established [sic] schedules of charges which were consistent with the intent that upper limits did not exceed amounts paid under Title XVIII for similar services.

* * * [O]ur regulations have not previously required HEW approval of the reimbursement methodology developed by the States for [Nursing Homes] * * *. Therefore, revisions to rates for periods prior to the implementation of 250.30 [a][3], [December 31, 1976] are not contrary to Federal regulations insofar as they meet the test of not exceeding amounts paid under Title XVIII.

He further stated that under the July 1, 1976 regulation (45 C.F.R. 250.30 [a][3]), which implements the statutory provision (§ 1396a [a][13][E]) upon which petitioners rely, the

[a]pproval of cost-finding methods takes place when State Plan amendments are submitted. The [revisions] to the [Medicaid] State Plan are due in the Regional Office by December 31, 1976.

Petitioners refer to this letter in their brief and do not challenge the propriety of this court's consideration of it.

The letter indicates that the HEW mechanism for approving changes in rate-making procedures was established by HEW to consider only changes effective after January 1, 1977. Therefore, it was not possible for the respondent Commissioner to obtain approval for the October, 1976 rates. Although section 1396a (a)(13)(E) on its face was to be effective July 1, 1976, it is impossible for this court to find that HEW, in waiting until January 1, 1977 to fully implement the approval mechanism, violated the statutory directive. This record contains no evidence of the exigencies faced by HEW in administering the Medicaid Plans of the several states.

Furthermore, even if a federal approval mechanism had been available, the respondent's failure to obtain approval for his October, 1976 rates would not justify the relief requested. Petitioners have not shown the October rates violate the substantive standard of section 1396a (a)(13)(E), which merely requires reimbursement rates to be set "on a reasonable cost related basis."

Finally, petitioners claim vested rights in the monies they have actually received during 1976 under the tentative rates set in November, 1975. They urge that this court's decision in White Plains Nursing Home v. Whalen (53 A D 2d 926) precludes the respondent from recouping the difference between the tentative rates and the October, 1976 rates he proposes to make retroactive to January 1, 1976.

Petitioners here were notified by November 1, 1975 of their individual tentative rates and that final 1976 rates reflecting "upward or downward revision will be promulgated as soon as possible" (Dept. of Health Mem., 75-159). In the White Plains Nursing Home case the Commissioner had set a reimbursement rate for 1975 for the petitioner White Plains Nursing Home with no indication that the rate was subject to change during 1975. We held that since petitioner White

Plains Nursing Home performed services in reliance on the apparently final 1975 rate, it had a property right in such rate which the Commissioner could not impair without a hearing.

No such reasonable reliance was possible by petitioners herein. They were free to refuse Medicaid patients if the reimbursement rate was below the fee they demanded from the public generally. The petitioners cite no statute requiring them to accept patients at the Medicaid rate, and the only regulation which arguably imposes such an obligation is 10 NYCRR 730.2 - - "[the operator shall] not discriminate because of race, color, blindness or sponsorship in admission, retention and care of patients." (Emphasis supplied.) There is nothing in this language which would preclude a nursing home from excluding any prospective patient who does not pay the established fee charged all patients. Neither does anything in the provider agreement referred to earlier, nor the general arrangement between the State and petitioners, imply such an obligation (cf. Matter of Sigety v. Ingraham, 29 N Y 2d 110, 115).

Since the petition will be dismissed, it is not necessary to decide if class relief, granted by Special Term, would have been appropriate.

The judgment should be reversed, on the law and the facts, and the petition dismissed, without costs. Upon service of a copy of the order to be entered hereon together with notice of entry, the preliminary injunction heretofore granted by order of this court, entered November 19, 1976, should be vacated.

KANE, J. P. (dissenting).

Although diplomatically called the establishment of a "tentative" rate by the majority, in plain words and fact the respondents simply froze 1976 Medicaid reimbursement rates at existing 1975 levels. This the majority says they were permitted to do by section 2803 of the Public Health Law. We disagree. It also concludes that chapter 76 of the Laws of 1976 authorized their later action in fixing new rates for 1976 retroactively and that such action neither impaired any contractual rights nor offended relevant Federal statutes and regulations. Again we disagree. The judgment of Special Term should be affirmed with certain modifications.

We believe that this proceeding was properly maintained pursuant to CPLR article 78. Petitioners' basic complaint is that respondents failed to perform their statutory duties and, in fact, exceeded their authority. While a determination fixing rates is involved, the petition does not ask for certiorari review of a matter ordinarily deemed a legislative act; it seeks redress in the classic nature of prohibition and mandamus to restrain an allegedly unauthorized activity and to compel compliance with those duties. In any event, we would not hesitate to treat the present litigation as an action for declaratory judgment (cf. Matter of Lakeland Water Dist. v. Onondaga Water Auth., 24 N Y 2d 400; Matter of White Plains Nursing Home v. Whalen, 53 A D 2d 926; Matter of Severino v. Ingraham, 45 A D 2d 564). However, petitioners did not obtain an order allowing them to maintain this proceeding as a class action (CPLR 902). Since Governmental operations are involved and subsequent petitioners would be adequately protected under the principles of stare decisis, the judgment of Special Term should be modified by deleting references to class relief (Matter of Jones v. Berman, 37 N Y 2d 42, 57).

Turning to the substantive aspects of this proceeding, it should be recalled that petitioners first questioned the lawfulness of the rate freeze in February of 1976. In answer to their petition, it was alleged that section 2808 of the Public Health Law supplanted all or a portion of section 2807 thereof and that certain fiscal considerations and statutory uncertainty made it necessary to approve "interim" rates. An affidavit of the respondent Commissioner of Health expanded on these justifications. The fiscal considerations were said to be the serious financial plight of the City of New York and its resulting impact on the budget of the State. The supposed statutory uncertainty was founded on the expected passage of a proposed Medicaid revision bill which would have frozen reimbursement rates from January 1, 1976 through March 31, 1977. The former reason undoubtedly supplied motivation to conserve State resources, but it hardly conferred authority on respondents to single out residential health care facilities as a target for effecting such savings. The latter explanation was completely worthless. In addition to the fact that the Legislature did not bring their prediction into reality, respondents were obviously not entitled to anticipate future legislation but were bound to follow the statutes then in existence until they were changed.

In apparent recognition of the inherent weakness of these arguments, the majority seizes upon respondents' reference to section 2808 of the Public Health Law and maintains that it set a new standard for the establishment of Medicaid reimbursement rates which authorized the freeze initially imposed. This will surely come as welcome news to respondents, particularly since they never claimed that statute possessed such a broad effect before Special Term or in their brief and argument in this court. The aforementioned affidavit of the Commissioner of Health merely stated that section 2808 "* * * appears to supplant all, or at least a portion of the traditional rate setting provisions of [s]ection 2807 * * *" and concluded in a self-serving fashion that "* * * [u]ntil this issue is resolved it would not be prudent to go forward with 1976 reimbursement." If this represents solid reliance on some newly found standard, it is a remarkably timid manner of expressing it. In our view that statute simply directed the promulgation of interim regulations, exactly as it was worded, and the Commissioner of Health apparently so understood it for he did adopt a new regulation pursuant thereto, before the rate freeze was imposed, which reaffirmed and continued the effectiveness of his former regulations (see former 10 NYCRR 86.34, eff. Oct. 14, 1975). Far from establishing any new standard, section 2808 required only that certain interim regulations be consistent with Federal regulations on the same subject. The standard contained in subdivision (3) of section 2807 was not repealed, as one might expect had the Legislature truly intended.

section 2808 to take its place, but remained intact and partially survived amendments made by chapter 76 of the Laws of 1976. Furthermore, even if what a "prudent buyer" would pay constitutes some type of standard, we fail to appreciate how it materially differs from the "costs of efficient production" language. Not often in the normal course of business may a careful buyer obtain something for less than the cost of its efficient production; he certainly cannot do so repeatedly for very long.

Finally, nowhere in the record or briefs before us have respondents even suggested that the frozen rates "closely approximated" the rates mandated by section 2808 as stated by the majority. Petitioners have not attempted to prove that the "tentative" rates were inconsistent with section 2808 because, until now, they were never given any reason to believe that statute might have played a part in respondents' decision to freeze those rates. The issue is not whether proper 1976 rates would be higher or lower than those in use during 1975, but whether respondents had authority to act as they did when they did. Nothing contained in section 2808 of the Public Health Law expressly or impliedly empowered respondents to set an interim or temporary rate and, pending the adoption of valid regulations thereunder, they were obliged to follow the statutes and regulations then in effect. Quite plainly they did not do so and, accordingly, we agree with Special Term that the rate freeze was illegal, null and void.

Our disagreement with the second conclusion of the majority stems from the interpretation we place on chapter 76 of the Laws of 1976. As a general rule, statutes are prospectively construed unless a clear legislative expression to the contrary appears (Matter of Mulligan v. Murphy, 14 N Y 2d 223; McKinney's Cons. Laws of N.Y., Book 1, Statutes, § 51). The majority finds such an expression in section 18 of that enactment whereby the amendments to subdivision 2 of section 2807 of the Public Health Law were deemed to have been in effect on and after January 1, 1976. However, the same section also provided that "* * * [t]his act shall not be construed to alter, change, affect, impair or defeat any rights, obligations, duties or interests accrued, incurred or conferred prior to the enactment of this act * * *" (L. 1976, ch. 76, § 18). While residential health care facilities have no property rights in prospective reimbursement rates, it seems clear to us that they do possess an "interest" in receiving payment for services already rendered which would be "affected" by a retroactive application of the challenged legislation. The language of the enactment is at least ambiguous and, therefore, we would decline to give it retrospective effect.

Assuming, arguendo, that petitioners' rates were properly frozen and that the Legislature meant to permit the retroactive application of chapter 76 of the Laws of 1976, two questions must still be resolved; could retroactive application of new rates be constitutionally accomplished without impairing contractual rights and did the particular action of the respondents in October of 1976 avoid the infringement of such rights?

Petitioners would surely not object to a retroactive windfall and the first inquiry poses difficulty only when the retrospective rates are lower than those previously in effect. La Crescent Constant Care Center, Inc. v. State Department of Public Welfare (301 Minn. 229, 222 N.W. 2d 87) supplies no answer when this occurs for there the petitioner was contending that its provider agreement had incorporated the State Plan and associated statutory standard so that it had an affirmative contractual right to a rate of reimbursement higher than was then being paid. No element of retroactivity was involved in that case. Here, however, petitioners are asserting that their provider agreements contain sufficient terms to serve as a defensive shield to a later reduction in those reimbursement rates and we agree. Residential health care facilities must execute provider agreements with the State as a precondition to participation in the Medicaid program (see, U.S. Code, tit. 42, § 1396a [a] [27]) and, having done so, the fact that no specific payment rates are set forth does not mean that a contractual accord with the State has not been achieved. Mention of the State Plan is obviously a shorthand device used to signify the contractual arrangement chosen by the parties for determining the method and amount of payment to be made for services rendered. We do not wish to imply that a provider agreement may never be altered through some prospective change in the State Plan, but no matter how the Legislature might validly suspend or change the obligations thereby created (see, Home Building & Loan Assn. v. Blaisdell, 290 U.S. 398; Matter of Department of Bldgs. of City of N.Y. [Philco Realty Corp.], 14 N Y 2d 291), it could not have intended nor would it have been constitutionally permissible to abrogate them retroactively (see, Flushing National Bank v. Municipal Assistance Corporation of the City of New York, ___ N Y 2d ___ [Nov. 19, 1976]; Patterson v. Carey, 52 A D 2d 171).

The answer to the second question is somewhat complicated by the fact that respondents have conceded on this appeal that their action in October of 1976 will produce a reimbursement rate which is higher for some residential health care facilities than the initially frozen rate while for others it will be even lower. Its effect on

these petitioners has not been developed in this record. Nevertheless, in our opinion petitioners' new 1976 rates may not be retroactively applied, following the foregoing analysis, if they are lower than the originally frozen rates. Parenthetically, this would also hold true if their new rates are lower than rates recalculated according to the statutes and regulations in effect on November 1, 1975, but we are still assuming that the primary freeze was valid and that chapter 76 of the Laws of 1976 was intended to be retroactively applied.

The majority discovers no necessity for petitioners to accept Medicaid patients and reasons that respondents' notification that the tentative reimbursement rates might be adjusted downward eliminated the need to accord them a hearing before recouping any difference between their frozen rates and the new rates. Although we do not think it necessary to presently decide whether residential health care facilities must accept Medicaid patients, these petitioners have alleged that they are required to do so and respondents have "admitted" that in their answer. The parties have thus foreclosed review of that issue in this proceeding and, for whatever their legal worth, 10 NYCRR 730.2 and the language of the provider agreements tend to support their stipulation. In any event, we are not actually concerned with whether the proposed recoupment works a deprivation of property (cf. Matter of Sigety v. Ingraham, 29 N Y 2d 110, 115), but whether it causes an impairment of contractual obligations. That it would most certainly do and no description of the original rate as being "tentative" or a subsequent hearing could cure that infirmity. Of course, absent the instant stipulation and provider agreements we would then face the situation addressed by the majority. If that were the case, we still fail to perceive how vested property rights in the form of payments made for services already rendered can be made to disappear according to the label applied to those payments in the first instance (Matter of White Plains Nursing Home v. Whalen, supra).

Lastly, our views obviate the necessity of considering the entire scope of petitioners' claim that the reimbursement freeze and retroactive application of new rates conflicts with certain Federal statutes and regulations (see, U.S. Code, tit., 42, § 1396a [a] [13] [E] and CFR 250.30 [a] [3]). Special Term properly decided this proceeding on the basis of New York law and adequately protected petitioners by directing the recomputation of 1976 rates. The additional injunctive relief granted was unnecessary and its judgment should be further modified accordingly. However, were it not for our declaration concerning the impermissibility of applying chapter 76 of the Laws of 1976 retroactively, we would be inclined to agree with petitioners on this point (see, Hospital Association of New York State Inc. v. Toia, ___ F. Supp. ___ [Nov. 5,

1976, No. 76 Civ. 2027]; Catholic Med. Center v. Rockefeller, 305 F. Supp. 1268, affd. 430 F. 2d 1297, app. dsmd. 400 U.S. 931). The opposite interpretation placed upon the HEW regulation by an administrator is not impressive when the statute seems to require his superior's approval and verification of cost-finding methods after July 1, 1976.

To recapitulate our position, although class action and injunctive relief were either unwarranted or unnecessary, respondents undertook the rate freeze without lawful authority. They should recalculate those rates in accordance with the statutes and regulations in effect on November 1, 1975 and make appropriate payments to petitioners if their recalculated rates prove to be higher than their frozen rates. Chapter 76 of the Laws of 1976 may not be utilized retroactively, but we have no reason to question the propriety or future application of rates established in conformity therewith. If retrospective application of that enactment were legally possible, the rates thereunder for such a period could not be lower than petitioners' recalculated rates and if the recalculation were itself unnecessary, the rates thereunder could not then be lower than those originally frozen.

The judgment of Special Term should be modified as indicated and affirmed.

10.

Judgment, Findings of Fact and Conclusions of Law
in California Hospital Association v. Obledo, Civil
Action No. 76-903-R (C.D. Cal. November 5, 1976)

LODGED

OCT 20 1976

CLERK, U.S. DISTRICT COURT
CENTRAL DISTRICT OF CALIFORNIA

CARL WEISSBURG and ROBERT A. MILEN
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By: JAMES E. LUDLAM
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Attorneys for Plaintiffs

JS-6
FILED

NOV 11 1976

CLERK, U.S. DISTRICT COURT
CENTRAL DISTRICT OF CALIFORNIA
BY [Signature] DEPUTY

ENTERED

UNITED STATES DISTRICT COURT

CENTRAL DISTRICT OF CALIFORNIA

NOV 11 1976

CLERK, U.S. DISTRICT COURT
CENTRAL DISTRICT OF CALIFORNIA
By [Signature]

CALIFORNIA HOSPITAL ASSOCIATION,)
a nonprofit California corpora-)
tion, and UNITED HOSPITAL)
ASSOCIATION, a nonprofit California)
corporation, et al.,)

Plaintiffs,

v.

MARIO OBLEDO, SECRETARY OF)
HEALTH AND WELFARE, STATE OF)
CALIFORNIA, et al.,)

Defendants.

NO. CV 76-903-R

J U D G M E N T

In accordance with the court's Findings of Fact and
Conclusions of Law of November 5, 1976,

IT IS HEREBY ORDERED, ADJUDGED, AND DECREED that Mario
Obledo, Secretary of Health and Welfare of California, and
Jerome A. Lackner, Director of the Department of Health, State
of California, and their successors, agents, employees and
attorneys, and all persons acting in concert with them, be and
hereby ordered to refrain from implementing or applying:

(a) The amendment to the California State Plan approved
by the Regional Commissioner of the Social and Rehabilitation

Service, Department of H.E.W., on March 31, 1976, purporting to impose as a limit on reasonable costs of inpatient hospital services provided to Medi-Cal patients an amount not to exceed a set percentage of a hospital's previous year's average daily costs.

(b) Any amendment to 22 California Administrative Code §§ 51508 - 51508.3 adopted after July 1, 1975, to date of entry of this judgment to cost reports heretofore or hereafter filed, including provisions concerning interim reimbursement to hospitals as set forth therein.

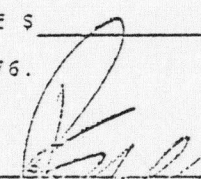
(c) Any set percentage limit on the amount of reasonable cost increase sustained by hospitals in rendering services to Medi-Cal beneficiaries.

IT IS FURTHER ORDERED, ADJUDGED, AND DECREED that defendant David Mathews, Secretary of H.E.W., and his successors, agents, employees and attorneys, and all persons acting in concert with him, be and hereby are enjoined from approving any purported amendment to the California State Plan which imposes a set percentage limit on the amount of reasonable cost increases sustained by California hospitals in providing services to Medi-Cal beneficiaries.

IT IS FURTHER ORDERED, ADJUDGED, AND DECREED that the freeze order, the amendment to the California State Plan which was approved on March 31, 1976, and the amendments to 22 California Administrative Code §§ 51508 - 51508.3 adopted after July 1, 1975, be and hereby are declared invalid.

IT IS FURTHER ORDERED, ADJUDGED, AND DECREED that plaintiffs shall recover costs in the amount of \$ _____.

DATED: November 5, 1976.


UNITED STATES DISTRICT JUDGE

UNITED STATES DISTRICT COURT
CENTRAL DISTRICT OF CALIFORNIA

CALIFORNIA HOSPITAL ASSOCIATION
etc., et al

PLAINTIFF

VS

MARIO DBLEDO, Secretary of Health,
and Welfare, et al

DEFENDANT

CASE NUMBER
CV76-902-R

NOTICE OF ENTRY

TO THE ABOVE NAMED PARTIES AND TO THEIR ATTORNEYS OF RECORD;

You are hereby notified that Judgment

in the above entitled case was entered in the docket on 11/11/76

You are also notified that if this case was tried and you introduced exhibits into evidence, they must be claimed at this office after the expiration of thirty days from the receipt of this notice. (After sixty days in cases in which the United States, its officers or agencies were parties) Unless they are claimed within thirty days after the expiration of the above period, they will be destroyed pursuant to Local Rule 10(a). If an appeal is taken they will, of course, be held until the Appellate Court finally determines the matter. Exhibits which are attached to a pleading will not be destroyed but will remain as a permanent record in the case file.

CERTIFICATE OF MAILING

I, Edward M. Kritzman, Clerk, United States District Court, Central District of California, and not a party to the within action, hereby certify that on 11/11/76 19__, I served a true copy of this notice of entry on the parties in the within action by depositing true copies thereof, enclosed in sealed envelopes, in the United States Mail in the United States Post Office mail box at Los Angeles, California, addressed as follows:

Evelle J. Younger
Attorney General, State of California
555 Capitol Mall, Suite 550
Sacramento, California 95814
Atten: Joseph O. Egan,
Deputy Atty. General

Carl Weissburg
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Los Angeles, California 90006

WILLIAM D. KELLER
U.S. Attorney
1100 U.S. Courthouse
213 North Spring Street
Los Angeles, California 90012
Attention: J. MARK WAXMAN, Asst.U.S.Atty

Musick, Peeler & Garrett
One Wilshire Blvd., Suite 200
Los Angeles, California 90017

NOTICE

IN ACTIONS ARISING UNDER THE ECONOMIC
STABILIZATION ACT, THE EMERGENCY
PETROLEUM ALLOCATION ACT AND THE
ENERGY POLICY AND CONSERVATION ACT,
NOTICES OF APPEAL TAKEN FROM THIS
JUDGMENT MUST BE FILED IN THE TEMPOR-
ARY EMERGENCY COURT OF APPEALS IN ACCOR-
DANCE WITH THE RULES OF PROCEDURE OF THAT
COURT.

EDWARD M. KRITZMAN, Clerk

By ELVA J. BROWN
Deputy Clerk

CIV 26 (3-76)

NOTICE OF ENTRY

1 CARL WEISSBURG and ROBERT A. KLEIN
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8 MICHAEL W. CONLON

LODGED October 26, 1976

FILED November 11, 1976

9 Attorneys for Plaintiffs

10

11

UNITED STATES DISTRICT COURT

12

CENTRAL DISTRICT OF CALIFORNIA

13

14 CALIFORNIA HOSPITAL ASSOCIATION,)
a nonprofit California corpora-)
15 tion, and UNITED HOSPITAL)
ASSOCIATION, a nonprofit California)
16 corporation, et al.,)

NO. CV 76-903-P

17

Plaintiffs,)

FINDINGS OF FACT AND

18

v.)

CONCLUSIONS OF LAW

19

MARIO OBLEDO, SECRETARY OF
HEALTH AND WELFARE, STATE OF
20 CALIFORNIA, et al.,)

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Defendants.)

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The above-entitled action came on regularly for trial in
the above-entitled court on October 18, 19 and 20, 1976, before
the Honorable Manuel L. Real, Judge. The plaintiffs were repre-
sented by Robert A. Klein, member of Weissburg and Aronson, Inc.,
and James B. Bertero of the firm of Musick, Peeler & Garrett; the
defendants Mario Obledo, Secretary of Health and Welfare, State
of California, and Jerome A. Lackner, M.D., Director of Health,
State Department of Health, State of California ("state defen-
dants") were represented by Patric Hooper and Joseph O. Egan,
Deputy Attorneys General for the State of California; and the

1 defendant David Mathews, Secretary of Health, Education and
2 Welfare ("federal defendant"), was represented by J. Mark Waxman
3 and Carolyn M. Reynolds, Assistant U. S. Attorneys. Evidence,
4 both oral and documentary, having been introduced by and on
5 behalf of all parties, the court, having considered the same and
6 heard and read the arguments of counsel, and being fully advised
7 in the premises, makes the following Findings of Fact and states
8 the following Conclusions of Law:
9

10 FINDINGS OF FACT
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12 1. The plaintiffs California Hospital Association and
13 United Hospital Association are nonprofit California corporations
14 together representing over 500 hospitals, each duly licensed
15 pursuant to California Health & Safety Code § 1250 as a general
16 acute care hospital facility. Each of the individual hospital
17 plaintiffs is a participant in the Medi-Cal program and provides
18 inpatient services to Medi-Cal patients.
19

20 2. The state defendants are the state officers primarily
21 responsible for the lawful administration of the Medi-Cal
22 program.
23

24 3. The federal Medicaid program provides grants of
25 federal monies to states implementing programs of medical
26 assistance to low-income and indigent persons when those state
27 programs conform to the requirements of the Medicaid program.
28 The participating states and the federal government share in the
29 cost of this program. The California state program implemented
30 pursuant to the Medicaid program is known as the Medi-Cal
31 program.
32

////

1 4. In the normal operation of the Medi-Cal program, after
2 the participating hospital has rendered inpatient services to
3 Medi-Cal patients it periodically submits its charges to the
4 state for reimbursement of its reasonable costs incurred in pro-
5 viding such services. Payment on these initial submissions is
6 generally referred to as interim payment. Within 90 days of the
7 close of a hospital's fiscal year a "cost report" is filed with
8 the state upon which final reimbursement is based.

9
10 5. Prior to July 1, 1975, hospitals participating in the
11 Medi-Cal program were reimbursed for their inpatient services to
12 Medi-Cal patients on the basis of reasonable costs as defined by
13 federal regulations implementing the Medicare program, which
14 regulations are found at 20 CFR 405.401 - 405.454.

15
16 6. On July 31, 1975, the state defendants issued a letter
17 (the "freeze order") to Medi-Cal Intermediary Operations, the
18 agency in charge of administering payments to participating
19 hospitals, which letter froze interim reimbursements to provider
20 hospitals for hospital inpatient accommodation reimbursement to
21 per diem rates on file June 30, 1975. The freeze order attempted
22 to limit interim reimbursement rates for inpatient accommodations
23 for the period beginning July 1, 1975. It was issued by Lee
24 Helsel, Deputy Director, Medi-Cal Division, California Department
25 of Health, under a subdelegation of authority from one Ben
26 Sifuentes to Mr. Helsel dated November 3, 1975, and a primary
27 delegation order dated August 25, 1975, from Jerome A. Lackner
28 to Mr. Sifuentes.

29
30 7. Said freeze order was not submitted to the federal
31 defendant prior to its implementation, and said freeze order was
32 issued and implemented by the state defendants without their

1 first complying with the requirements of the California Ad-
2 ministrative Act.

3
4 8. On or about March 26, 1975, the state defendants sub-
5 mitted to the Regional Commissioner for Region IX of the Social
6 and Rehabilitation Service ("SRS") of the Department of H.E.W.
7 a proposed amendment to the California State Plan which redefined
8 "reasonable costs" for purposes of reimbursement to hospitals for
9 inpatient services provided to Medi-Cal patients as being equal
10 to the costs per patient day reimbursed to that hospital for a
11 base period plus an amount not to exceed ten percent of such
12 cost. Said proposal appears at pages 235 through 244 of the
13 Federal Administrative Record and pages 109 through 113 of the
14 California Administrative Record. Such submission included the
15 economic justification for the proposed amendment.

16
17 9. The economic forecasting methodology which was part of
18 the economic justification was never the subject of independent,
19 critical review by the Regional Commissioner or his subordinates.

20
21 10. The method of economic forecasting utilized by the state
22 defendants failed to take into account certain factors, including
23 changing service intensity as a major factor contributing to in-
24 creasing hospital costs, and the wide variation and differentiation
25 among the cost structures of individual participating hospitals.

26
27 11. On December 31, 1975, the state defendants adopted a
28 regulation amending § 51508, Title 22, California Administrative
29 Code; said amendment states in pertinent part:

30
31 "(a) Final settlement for acute care
32 services furnished to Medi-Cal program beneficiaries

1 by hospitals shall not exceed the lesser of
2 the reasonable cost of such services or the
3 customary charges therefor to the general
4 public.

5 "(1) Reasonable cost for services rendered on
6 and after July 1, 1975, through June 30, 1976,
7 shall mean an amount not more than the average
8 total cost per patient day of service for the
9 immediate 12 months preceding July 1,

10 1975, plus ten percent of said average cost.

11 Average cost per patient day of service shall
12 be determined from the hospital's cost statement
13 for the last full cost reporting period ending
14 prior to July 1, 1975, and adjusted for actual
15 costs incurred after such reporting period and
16 prior to July 1, 1975.

17 "(2) The Department shall use the 'Health
18 Insurance Regulations Manual' (HIRM-1) as issued
19 and amended by the U. S. Department of Health,
20 Education and Welfare for the administration of
21 Title XVIII of the Social Security Act as amended;
22 said manual shall be used by the Department as a
23 guide for determining reasonable costs.

24 "(3) Interim payments to hospitals shall
25 be determined by the use, and adjustment to cur-
26 rent status of previous year cost information.
27 Interim payments shall not exceed the level of
28 interim payment for the previous month by more
29 than eight-tenths of one percent."

30
31 (hereinafter referred to as the "ten percent limit.")

32 ////

1 12. The ten percent limit superseded the freeze order.

2

3 13. On March 31, 1976, the federal defendant, acting
4 through his Regional Commissioner of SRS, executed a "Transmittal
5 and Notice of Approval of State Plan Material," approving the
6 amendment to the California State Plan embodied in the ten
7 percent limitation.

8

9 14. On June 1, 1976, the state defendants adopted a
10 further amendment to 22 California Administrative Code § 51508
11 to add §§ 51508.1 through 51508.8 (the "appeals procedure
12 amendment"), which purported to provide extraordinary administra-
13 tive relief from the application of the ten percent limit. Said
14 regulation was issued by Lee Helsel pursuant to the previously-
15 mentioned subdelegation order.

16

17 15. On June 29, 1976, the state defendants adopted a
18 further amendment to 22 California Administrative Code § 51508
19 defining "reasonable costs" for inpatient services provided to
20 Medi-Cal patients as being equal to the cost per patient day
21 reimbursed to a hospital for a base period plus an amount not
22 to exceed seven percent of such costs. The seven percent reim-
23 bursement limit was to apply for the fiscal year beginning
24 July 1, 1976. Said regulation was adopted on an emergency
25 basis and was issued by Mr. Helsel pursuant to the aforesaid
26 subdelegation order. Said regulation was adopted without prior
27 compliance with the requirements of the California Administrative
28 Procedure Act, was adopted without prior federal approval, was
29 adopted in the absence of an emergency, and was adopted without
30 a hearing ever held thereon.

31 ////

32 ////

1 16. The regulation imposing the ten percent limit expired
2 on June 30, 1976. Since July 1, 1976, the state defendants have
3 continued to implement the ten percent limit by limiting monthly
4 reimbursement rates thereunder to an amount not to exceed the
5 level of interim payment for the previous month by more than
6 eight-tenths of one percent.

7
8 17. Each of the individual plaintiff hospitals other than
9 Samuel Merritt Hospital and West Adams Community Hospital
10 sustained damage by reason of the imposition of the ten percent
11 limit.

12
13 CONCLUSIONS OF LAW
14

15 1. Jurisdiction resides in this court and venue lies in
16 this judicial district.

17
18 2. This litigation is ripe for judicial resolution.

19
20 3. The Association plaintiffs have standing.

21
22 4. The freeze order is invalid.

23
24 5. The state plan was not validly adopted.

25
26 6. 42 U.S.C. § 1396 et seq. and 45 CFR 205.30 do not
27 permit a state plan to define reasonable costs for purposes of
28 reimbursement to hospitals for their costs of providing in-
29 patient services to Medi-Cal patients as being subject to a fixed
30 ceiling or limit.

31
32 7. The State Plan did not provide for incentives for

1 efficiency and economy, nor did it provide reimbursement on a
2 reasonable costs basis.

3
4 8. Implementation of the amendment to the State Plan,
5 including the regulations issued under it and as a part of it, in
R 6 advance of any ~~expressed~~ approval received from the Secretary
7 of H.E.W. was invalid.

8
9 9. The appeals procedure amendment did not provide a
10 reasonable alternative method for hospitals to obtain costs to
11 which they are entitled by law.

12
13 10. The appeals procedure amendment was invalidly adopted.

14
15 11. The seven percent limitation emergency regulation was
16 invalidly adopted.

17
18 12. Plaintiffs are entitled to a judgment consistent with
19 the foregoing Findings and Conclusions, and for their costs of
20 suit herein.

21
22 DATED: November 5, 1976.

23
24
25
26 /s/ REAL
UNITED STATES DISTRICT JUDGE

11.

Decision in New Jersey Hospital Association v. Klein,
Civil Action No. 76-64 (D. N.J. April 9, 1976)

4/9/76.

UNITED STATES DISTRICT COURT
DISTRICT OF NEW JERSEY

NEW JERSEY HOSPITAL ASSOCIATION, a :
non-profit New Jersey corporation; :
NEWARK BETH ISRAEL MEDICAL CENTER, :
a non-profit New Jersey corpora- :
tion; UNITED HOSPITALS OF NEWARK, : Civil Action No. 76-64.
a non-profit New Jersey corpora- :
tion; and SAINT MICHAEL'S MEDICAL :
CENTER, a non-profit New Jersey :
corporation, :

Plaintiffs, :

v. :

OPINION

ANN KLEIN, Commissioner of Insti- :
tutions and Agencies of the State :
of New Jersey, and RICHARD C. :
LEONE, Treasurer of the State of :
New Jersey, :

Defendants. :

BARLOW, District Judge.

Appearances:

EUGENE M. HARING, Esquire
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WILLIAM F. HYLAND, Esquire
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BY: ROBERT E. POPKIN, Esquire
Deputy Attorney General
(Attorney for Defendants)

The plaintiffs here challenge Rule 10:49-1.28, 7 N.J. Register 557, of the Division of Medical Assistance and Health Services of the New Jersey Department of Institutions and Agencies. The questioned rule was issued by Allen J. Gibbs, Acting Commissioner of the Department of Institutions and Agencies, on behalf of the defendant Ann Klein, Commissioner of Institutions and Agencies of the State of New Jersey. The other named defendant is Richard C. Leone, Treasurer of the State of New Jersey. The plaintiffs are Newark Beth Israel Medical Center, United Hospitals of Newark, Saint Michael's Medical Center -- all hospitals located in the City of Newark, New Jersey -- and the New Jersey Hospital Association.

The disputed rule provides as follows:

"Effective January 1, 1976, payments made by the Division of Medical Assistance and Health Services to hospitals providing services to Medicaid recipients shall be established at a level sufficient to limit the FY 1975-1976 average per diem increase to 6.7 per cent over the appropriate base period."

This opinion is addressed to plaintiffs' application for a preliminary injunction which would restrain the defendant state officials from enforcing the 6.7 per cent ceiling established by the rule.

In order to obtain a preliminary injunction, the moving party must demonstrate: (1) a reasonable likelihood of ultimate success on the merits; (2) the probability of irreparable injury should the preliminary injunction not issue; (3) the absence of substantial hardship to other parties interested in the case should the preliminary injunction be issued; and (4) the favorable impact of a preliminary injunction on the public interest. See A. O. Smith Corp. v. Federal Trade Commission, No. 75-1292/89 (3d Cir., February 11, 1976), slip opinion at 22-3; Winkelman v. New York Stock Exchange, 445 F.2d 786, 789 (3d Cir. 1971); Nelson v. Miller, 373 F.2d 474, 477 (3d Cir. 1967), cert. denied, 387 U.S. 924 (1967).

LIKELIHOOD OF SUCCESS

In the present case, we think that plaintiffs have demonstrated that they are likely to succeed on the merits of this lawsuit. Plaintiffs' primary claim is that New Jersey's 6.7% ceiling rule conflicts with the federal Medicaid statutory provision which requires states participating in the Medicaid program to pay the "reasonable cost" of inpatient hospital services. 42 U.S.C. § 1396a(a)(13)(D).^{1/} Under the Supremacy Clause of the United States Constitution, Article VI, Clause 2, if a state accepts federal grant money, the state's statutes and regulations must conform to applicable federal statutes and regulations. See Hagans v. Lavine, 415 U.S. 528 (1974); Townsend v. Swank, 404 U.S. 282 (1971); King v. Smith, 392 U.S. 309 (1968). This principle has been held specifically to apply to the Medicaid program. See Doe v. Beal, 523 F.2d 611, 614-19 (3d Cir. 1975); Catholic Medical Center of Brooklyn and Queens, Inc. v. Rockefeller, 305 F.Supp. 1268 (E.D.N.Y. 1969), aff'd, 430 F.2d 1294 (2d Cir. 1970), appeal dismissed, 400 U.S. 931 (1970); Massachusetts General Hospital v. Sargent, 397 F.Supp. 1056, 1061-2 (D. Mass. 1975).

1. This provision states as follows:

"(a) A State plan for medical assistance must--

* * *

(13) provide--

* * *

(D) for payment of the reasonable cost of inpatient hospital services provided under the plan, as determined in accordance with methods and standards, consistent with section 1320a-1 of this title, which shall be developed by the State and reviewed and approved by the Secretary and (after notice of approval by the Secretary) included in the plan, except that the reasonable cost of any such services as determined under such methods and standards shall not exceed the amount which would be determined under section 1395x(v) of this title as the reasonable cost of such services for purposes of subchapter XVIII of this chapter"

- 4 -

In New Jersey, prior to the imposition of the rule which inspired the present lawsuit, "reasonable cost" was calculated pursuant to the cost principles established for the federal Medicare program. New Jersey State Plan for Medical Assistance, subparagraph IV(c) (5). See 42 U.S.C. § 1395x(v) (1) (A); 20 C.F.R. 405.402-405.455. Essentially, hospitals were reimbursed for their audited per diem cost per Medicaid patient, less any cost found by the state agency to be unnecessary. Each year, on an interim basis, hospitals would be reimbursed for their Medicaid costs at the same rate as that approved for the Blue Cross insurance program. At the end of the year, audits would be conducted, and the appropriate final per diem rates established. Under the rule challenged in the present case, however, the increase in the average per diem rate for fiscal year 1975-76 is not to exceed 6.7%. Since the established ceiling is to be applicable even if the increase in reasonable costs for 1975-76 actually exceeds 6.7%, the plaintiffs urge that the ceiling rule, on its face, violates the reasonable cost provision of the federal Medicaid law. We agree.

The defendants do not contend that the 6.7% ceiling is based on a projection of the actual rate of inflation in the hospital industry. Rather, the 6.7% figure apparently represents the amount of money deemed available for inpatient hospital services within the constrictions imposed by the state's budget. See Affidavit of Ann Klein. As such, the ceiling, on its face, is patently arbitrary in terms of any relation it has to reasonable cost levels. Obviously -- and particularly during an inflationary period -- a reimbursement plan cannot establish an arbitrary ceiling on increases in payments, and still purport to be based on reasonable costs. Accordingly, unless at trial we become convinced that the 1975-76 increase in reasonable costs is 6.7% or less, we would be disposed to hold New Jersey's ceiling rule invalid.

The defendants argue that the "reasonable cost" provision of federal law should not be so rigidly applied, insisting that Congress intended to grant the states considerable flexibility in setting Medicaid reimbursement levels. We do not disagree with that general proposition. Congress indicated such an intent by establishing optional programs, see 42 U.S.C. §1396a(a)(13)(B) and 42 U.S.C. § 1396d(a)(6)-(17), and by not requiring all mandatory programs to be funded on a full reasonable cost basis. See 42 U.S.C. § 1396a(13)-(14). However, Congress clearly did not intend such fiscal flexibility to apply to inpatient hospital services. The relevant statutory provision states that "[A] State plan for medical assistance must . . . provide . . . for payment of the reasonable cost of inpatient hospital services provided under the plan " 42 U.S.C. § 1396a(a)(13)(D). (Emphasis added.) We can find no warrant in this unambiguous statutory language, nor in the legislative history cited by the defendants, for reimbursing provider hospitals at less-than-reasonable cost for inpatient services. See Massachusetts General Hospital v. Sargent, *supra*, 397 F.Supp. at 1061-2; cf. Connecticut State Dep't of Public Welfare v. Dep't of HEW, 448 F.2d 209, 213-4 (2d Cir. 1971).

There is another reason for our conclusion that plaintiffs are likely to succeed on the merits of their suit. Contrary to the explicit requirements of 42 U.S.C. § 1396a(a)(13)(D), see text of this provision at n. 1, *supra*, the State of New Jersey has adopted and implemented its 6.7% ceiling rule before receiving the approval of the Secretary of Health, Education and Welfare (HEW).

Pre-implementation approval also is clearly required by an HEW regulation. 45 C.F.R. § 250.30.2/ It would seem clear, then, that the implementation of the 6.7% ceiling without prior HEW approval is not permissible under controlling federal law. Cf. Rhodes v. Harder, 211 Kan. 820, 508 P.2d 959, 966 (Kansas 1973), modified on other grounds, 212 Kan. 500, 512 P.2d 354 (Kansas 1973).

We find no merit in defendants' ingenious argument that the approval provisions are only for the benefit of HEW, and if HEW does not protest the pre-approval implementation of New Jersey's rule, the hospitals affected by the rule cannot do so. In our view, the approval provisions probably were intended, in part, to protect hospitals from being compelled to treat Medicaid patients on a less-than-cost basis. Cf. 1965 U.S. Code Congressional and Administrative News 1976-78 (Senate Report No. 404). Moreover, even assuming, arguendo, that the approval provisions have no relationship to the interest of hospitals, a well-established line of authority holds that once a party demonstrates his standing to challenge a particular state or agency action,^{3/} he may rely on any illegality in the

2. This regulation provides as follows:

"(a) State plan requirements. A State plan for medical assistance under title XIX of the Social Security Act must:

* * *

(2) Provide for payment of the reasonable cost of inpatient hospital services as determined in accordance with methods and standards, consistent with the provisions of section 1122 of the Social Security Act for participating States, which shall be developed by the State and approved in advance of implementation by the Regional Commissioner, Social and Rehabilitation Service. . . ."

3. Clearly the plaintiffs here have standing to challenge the 6.7% rule. See Massachusetts General Hospital v. Sargent, supra, 397 F.Supp. at 1059.

challenged decision, even if, in so doing, the challenger is asserting the public interest or a third party's interest, rather than reflecting his own private interest. See Sierra Club v. Morton, 405 U.S. 727, 727-8 (1972); Pierce v. Society of Sisters, 268 U.S. 510 (1925). See generally 3 K. Davis, Administrative Law Treatise, §§ 22.05-22.07 (1958).

ABSTENTION

Plaintiffs' complaint suggests a number of alternate grounds for relief. Included are claims under the New Jersey Administrative Procedure Act, N.J.S.A. 52:14B-1, et seq., and under a contract between plaintiff hospitals and the Department of Institutions and Agencies. Plaintiffs allege that these state claims are cognizable here under the doctrine of pendent jurisdiction. Relying on the existence of these state claims and other considerations, the defendants urge this Court to abstain from deciding the federal issues before us and to allow the matter to be litigated within the state court system. In our view, however, abstention is not warranted in the circumstances of this case.

The abstention doctrine, as such, was first enunciated in Railroad Commission v. Pullman Co., 312 U.S. 496 (1941). The so-called "Pullman doctrine" provides that "when a federal claim is premised on an unsettled question of state law, the federal court should stay its hand in order to provide the state courts an opportunity to settle the underlying state law question and thus avoid the possibility of unnecessarily deciding a constitutional question" Harris County Commissioners Court v. Moore, 420 U.S. 77, 83 (1975).

In addition to serving the time-honored judicial policy of avoiding unnecessary constitutional decisions, see Siler v. Louisville & Nashville R. Co., 213 U.S. 175, 191-93 (1909), abstention also tends to minimize state-federal friction. See Kusper v. Pontikes, 414 U.S. 51, 54-5 (1973); Railroad Commission v. Pullman Co., supra, 112 U.S. at 500-01.

In recent years, the Supreme Court has recognized the delay and expense inherent in many abstention situations and, accordingly, has confined the application of the doctrine to narrowly limited "special circumstances". See Colorado River Water Conservation Dist. v. United States, 44 U.S.L.W. 4372, 4376-77 (U.S. March 1, 1976); Harris County Commissioners Court v. Moore, supra, 420 U.S. at 83; Kusper v. Pontikes, supra, 414 U.S. at 54; Lake Carriers Ass'n v. MacMillan, 406 U.S. 498, 509 (1972). Typically, the doctrine is invoked where the constitutionality of a state statute is challenged, and the statute is susceptible of a construction by the state courts which would avoid the necessity of reaching the federal constitutional issue. Kusper v. Pontikes, supra, 414 U.S. at 54. See, e.g., Consumers Oil Corp. of Trenton v. Phillips Petroleum Co., 488 F.2d 816 (3d Cir. 1973); Charltonie v. Kugler, 509 F.Supp. 256 (D.N.J. 1973) (3-judge court). This case clearly does not involve such circumstances. Here, unlike the typical abstention situation, the federal claim does not turn upon an unsettled area of state law. Rather, the plaintiffs' complaint merely recites alternative grounds, some of which arise under state law, for invalidating the ceiling rule. Such a situation, absent unusual circumstances, compare Reetz v. Bozanich, 397 U.S. 82 (1970), does not demand abstention. Cf. Harris County Commissioners Court v. Moore, supra, 420 U.S. at 84; Wisconsin v. Constantineau, 400 U.S. 433 (1971).

Moreover, abstention is not appropriate here because the present case does not involve a federal constitutional question, except in the most formal sense. While we recognize that the Supremacy Clause would be the underlying authority for any determination that New Jersey's ceiling rule is violative of federal law, such a determination would not be dependent on an interpretation of the Constitution, but, rather, on an analysis of statutory and regulatory provisions. See discussion of "Likelihood of Success", supra. For this same reason, the Supreme Court has declined to require three-judge courts for Supremacy Clause claims. Swift & Co. v. Wickham, 382 U.S. 111 (1965). We are satisfied that if Supremacy Clause claims are not "constitutional" for three-judge court purposes, such issues similarly should not be considered "constitutional" for purposes of the abstention doctrine.^{4/} Thus, the present case does not involve the policy of avoiding unnecessary constitutional decisions. In these circumstances, the need for abstention loses much of its force. Cf. Propper v. Clark, 337 U.S. 472, 490 (1949).

There are rare cases, of course, where the threat of state-federal friction is so pronounced that a federal court should abstain even in the absence of a federal constitutional issue, or,

4. Significantly, both the three-judge court provision, 28 U.S.C. § 2281, and the abstention doctrine are premised, at least in part, on the same policy: avoiding state-federal friction. Compare Swift & Co. v. Wickham, supra, 382 U.S. at 116-19, with Railroad Commission v. Pullman Co., supra, 312 U.S. at 500-01. In our view, the invalidation of a state statute or policy on the ground that it conflicts with a federal statute is likely to be far less offensive to the state than an invalidation based on the due process and equal protection guarantees of the Fourteenth Amendment. We think it significant that virtually all cases in which abstention has been ordered involve equal protection and/or due process challenges to state statutes. See, e.g., Harris County Commissioners Court v. Moore, supra; Lake Carriers' Assn. v. MacMillan, supra; Railroad Commission v. Pullman, supra. The present case, of course, primarily involves a Supremacy Clause claim. Due process and equal protection claims, while raised in the complaint, have not been urged by the plaintiffs on the present motion, and we see no need to reach such claims under the doctrine of Hagens v. Levine, supra.

indeed, any federal issue at all. See, e.g., Louisiana Power & Light Co. v. City of Thibodaux, 360 U.S. 25 (1959). There are other cases, also uncommon, where there is no possibility of a "saving construction" in the state courts, but the federal issue so involves local considerations and policies that the litigation should be permitted to proceed in the state courts. See, e.g., Alabama Pub. Serv. Commission v. Southern Ry., 341 U.S. 341 (1951); cf. Reetz v. Bozanich, *supra*. We do not think that the type of abstention recognized in the City of Thibodaux and Alabama Pub. Serv. Commission cases has any application to the present case. While we have no doubt that the present dispute could be litigated in the state court system, we do not find any peculiar "localness" here such that the state or its citizens would be offended by our decision on a rather simple federal statutory issue. Accordingly, we decline to abstain.

IRREPARABLE INJURY

Even though we are satisfied that plaintiffs are likely to succeed on the merits of their case, and we find no basis for this Court to abstain, we must, nevertheless, decline to issue a preliminary injunction.

On the basis of the proofs presented, plaintiffs have not convincingly demonstrated that an imminent and irreparable injury will result from our failure to preliminarily enjoin the application of the disputed regulation. Elementary principles of equity jurisprudence, of course, prohibit the granting of a preliminary injunction except upon a showing of irreparable injury. National Land & Investment Co. v. Specter, 428 F.2d 91, 97 (3d Cir. 1970).

In the present case, plaintiffs' witnesses^{5/} testified, in somewhat conclusory terms, that the cash flow problems engendered by the ceiling rule are likely to cause serious and irremediable cutbacks in the services offered at many hospitals, especially those urban hospitals which are heavily dependent on Medicaid revenues. Plaintiffs' witnesses readily conceded, however, that the urban hospitals' financial plight pre-existed the implementation of the 6.7% ceiling rule. Although one witness insisted that the ceiling rule might well be "the straw that broke the camel's back", we think that the ceiling in reality would be only a contributing cause of the hospitals' fiscal problems. Plaintiffs' witnesses were unable, to establish any specific injuries which were primarily caused by the ceiling rule. Moreover, the total amount of the reduction in payments resulting from the application of the ceiling rule (approximately \$12,000,000.) represents a minor portion of the total annual expenditures of New Jersey hospitals.

Finally, we must emphasize that the plaintiff-hospitals ultimately will receive all the funds they are entitled to, should this Court sustain their challenge to the 6.7% rule. While it may be true that the Eleventh Amendment of the Federal Constitution prevents this Court from directly ordering retroactive payments, Massachusetts General Hospital v. Sargent, *supra*, 397 F.Supp. at 1062-3; see Edelman v. Jordan, 415 U.S. 651 (1974), Commissioner Klein as well as Deputy Attorney General Robert E. Popkin, has represented to the Court that the State is prepared to make the appropriate retroactive payments to the hospitals should the Court hold the ceiling rule to be illegal. See Affidavit of Ann Klein, at par. 20. In these circumstances, where the plaintiff-hospitals have not demonstrated that they are in imminent danger of financial collapse due to the ceiling rule, and where the hospitals ultimately may obtain

5. Plaintiffs' witnesses were Jack W. Owen, President of the New Jersey Hospital Association, William J. Cornetta, President of Saint Michael's Medical Center, and Gerald J. Reilly, Director of the Division of Medical Assistance and Health Services, New Jersey Department of Institutions and Agencies. The defendants presented no witnesses on their own behalf.

any funds to which they are entitled, we are unable to find that degree of immediate and irreparable injury which would justify the issuance of a preliminary injunction. In light of this view, it is unnecessary to discuss the "hardship to others" and "public interest" factors which occasionally influence the grant or denial of a preliminary injunction.

SUMMARY JUDGMENT

Ordinarily, our failure to find irreparable injury would conclude our inquiry on a preliminary injunction application. However, during oral argument, counsel for plaintiffs suggested that we treat the preliminary injunction application as a motion for summary judgment. Such a procedure is appropriate in rare cases where it is apparent from the record developed on the preliminary injunction application that one of the parties is entitled to judgment as a matter of law. See Standard Oil Co. of Texas v. Lopeno Gas Co., 240 F.2d 504, 509-10 (5th Cir. 1957); Walsh v. Local Board No. 10, 305 F.Supp. 1274, 1279 (S.D.N.Y. 1969). Here, the defendants do not deny that the ceiling rule has been implemented without the prior approval of the Secretary of HEW. As we have previously indicated, our view is that pre-implementation approval is clearly required by federal law. 42 U.S.C. § 1396a(a)(13)(D); 45 C.F.R. § 250.30. Accordingly, we will enter summary judgment for plaintiffs on that content on alone.

In so holding, we expressly decline to enter summary judgment on the underlying merits of the present case. While we agree with plaintiffs' interpretation of the federal "reasonable

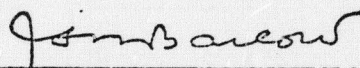
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cost" requirement, see discussion of "Likelihood of Success", supra, we think that the state may well be able to establish a factual dispute as to whether the 6.7% ceiling will result in reimbursement at less-than-reasonable cost.^{6/} Indeed, to us the word "reasonable" itself suggests a considerable factual inquiry. Summary judgment, of course, is inappropriate where material factual issues remain to be resolved. FED. R. CIV. P. 56(c).

REMEDY

In accordance with this opinion, judgment will be entered declaring and adjudging the implementation of Rule 10:49-1.28 to be illegal and improper until appropriate notice of approval is received from the Secretary of HEW. Further, there being no indication that the defendants will refuse to comply with the declaratory judgment granted here, an injunction to require compliance with the order reflecting this opinion is not required. See Massachusetts General Hospital v. Sargent, supra, 397 F.Supp. at 1062-3. Plaintiffs' application for a preliminary injunction is denied.

The foregoing constitutes the Court's findings of fact and conclusions of law pursuant to FED. R. CIV. P. 52(a). An appropriate order will be submitted.



George H. Barlow
United States District Judge

6. In this connection, we note that New Jersey State Health Commissioner Joanne Finley recently approved interim Blue Cross reimbursement rates with increases at an average of 5%. See The Star Ledger, March 5, 1976, at 1. If this percentage accurately reflects the rate of increase in hospitals' reasonable costs, the defendants' 6.7% ceiling might survive under the federal "reasonable cost" standard.

12.

Order in Virginia Hospital Association v. Kenley,
Civil Action No. 76-0300-R (E.D. Va. December 3, 1976)

IN THE UNITED STATES DISTRICT COURT
FOR THE EASTERN DISTRICT OF VIRGINIA
RICHMOND DIVISION

VIRGINIA HOSPITAL ASSOCIATION,)
ET AL.,)

Plaintiffs,)

v.)

DR. JAMES B. KENLEY, ET AL.,)

Defendants.)

Civil Action No. 76-0300-R

FILED

DEC 3 - 1976

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RICHMOND, VA.

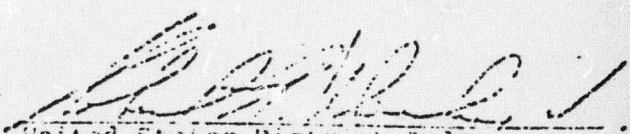
ORDER

For the reasons stated in the Memorandum of the Court this day filed and deeming it proper so to do, it is ADJUDGED and ORDERED that the defendants, their agents, servants, employees and all others acting in concert therewith be, and they are hereby, mandatorily enjoined from imposing the 14/21-day limitation on inpatient hospital care under the Virginia Medicaid Program.

Nothing in this Order is to be construed to limit the right of the defendants at any time to seek dissolution or modification of the injunction entered herein, upon certifying to the Court their compliance with the procedural prerequisite requirements of federal law regarding a reduction of Medicaid benefits.

This Order shall remain in full force and effect until the further order of the Court.

Let the Clerk send copies of this Order and the accompanying Memorandum to all counsel of record.


United States District Judge

Date: DEC 3 1976

IN THE UNITED STATES DISTRICT COURT
FOR THE EASTERN DISTRICT OF VIRGINIA
RICHMOND DIVISION

VIRGINIA HOSPITAL ASSOCIATION,)
ET AL.,)

Plaintiffs,)

v.)

DR. JAMES E. KENLEY, ET AL.,)

Defendants.)

Civil Action No. 76-0300 R

FILED

1976-1978

CLERK, U.S. DIST. COURT
RICHMOND, VA.

MEMORANDUM

Plaintiffs, the Virginia Hospital Association, who sues individually and on behalf of its membership of approximately 129 hospitals and related medical service facilities located throughout the Commonwealth of Virginia, three hospitals located in Virginia who participate in the Virginia Medical Assistance Program (hereinafter referred to as "State Plan"); and two individual residents of Virginia who are eligible for and have received medical assistance and in-patient hospital services pursuant to the State Plan bring this action for declaratory and injunctive relief and damages challenging the provisions of the Virginia Medical Assistance Program (implemented and administered pursuant to regulations promulgated in accordance with Section 32-30.1 of the Code of Virginia, as amended) as being in conflict with and violative of Title XIX of the Social Security Act, 42 U.S.C. § 1396 et seq. (hereinafter referred to as the Medicaid Act), Article I § 10 and Article VI of the United States Constitution, the Fifth and Fourteenth Amendments to the United States Constitution and the Civil Rights Act of 1971, 42 U.S.C. § 1983. The named Association and the named

Hospitals have each sued on its own behalf and on behalf of all of the hospitals in the Commonwealth of Virginia similarly situated and seek to represent the class composed of all providers of inpatient hospital services who are eligible for reimbursement in accordance with the rules and regulations promulgated under the State Plan and who are, have been or will in the future be denied reimbursement for inpatient hospital services provided to eligible recipients to the extent that such recipients remain hospitalized beyond a period of 14 days, except in cases of extended hospitalization as based on a determination of medical necessity and authorized by the State Department of Health, in which event such providers are, have been or will in the future be denied reimbursement for all such services provided to eligible recipients beyond the 21st day of hospitalization without regard to the extent or nature of the services required by the particular recipient.

Individual plaintiffs bring the action on their own behalf and on behalf of all other persons in the Commonwealth of Virginia similarly situated and seek to represent a class consisting of all those individuals in the Commonwealth of Virginia who are, have been or will in the future be eligible for medical assistance pursuant to the State Plan and the Medicaid Act, and who are, have been or will in the future be denied medical assistance for inpatient hospital services to the extent that they remain hospitalized beyond a period of 14 days, except in cases of extended hospitalization as based on a determination of medical necessity and authorized by the State Department of Health, in which event such eligible recipients are, have been or will in the future be denied medical assistance beyond the 21st day of hospitalization without regard to the nature or seriousness of the illness, disease or injury suffered by the particular recipient.

The named defendants include James B. Kenley, individually and as Commissioner of Health for the Commonwealth of Virginia, Mack I. Shanholtz, individually and as former Commissioner of Health for the Commonwealth of Virginia, Freeman C. Hays, individually and as Medical Director of the Virginia Medical Assistance Program, Otis L. Brown, individually and as Secretary of Human Affairs for the Commonwealth of Virginia, Mills E. Godwin, individually and as Governor of the Commonwealth of Virginia, Drs. John D. Buckley, Samuel W. Crickenberger, Kenneth M. Haggerty, Robert S. Hutcheson, Jr., Thomas C. Iden, William S. Terry, John H. VanHoy, Fletcher S. Wright, Jr., and Mrs. Fostine G. Riddick, individually and as members or former members of the Board of Health of Virginia, Robert C. Watts, Jr., individually and as Treasurer of the Commonwealth of Virginia, Charles B. Walker, individually and as Comptroller of the Commonwealth of Virginia and David Matthews, individually and as Secretary of the United States Department of Health, Education and Welfare (HEW).

Jurisdiction is attained pursuant to 28 U.S.C. §§ 1331(a), 1343(3), and 1343(4).

The matter is before the Court on the motion of plaintiffs for a preliminary injunction and defendants' respective motions for summary judgment.

The Court has considered the pleadings, as well as the evidence taken in support of plaintiffs' application for preliminary relief, and deems the matters ripe for disposition.

Plaintiffs attack the Virginia Medicaid provisions both on the statutory grounds that same are inconsistent with Title XIX of the Social Security Act, 42 U.S.C. § 1396, et seq. and additionally on the constitutional grounds that same violate Article I § 10, Article IV, the Fifth Amendment and the Fourteenth Amendment to the United States Constitution. In the case of Hagins v. Lavine, 415 U.S. 528 (1974), the

Supreme Court reversed the dismissal of a suit challenging New York Regulations under the Aid to Families with Dependent Children (AFDC) provisions of the Social Security Act, 42 U.S.C. § 601 et seq., holding that the constitutional claim was sufficient to confer jurisdiction on the Court under 28 U.S.C. § 1943(3), but required the Court on remand to consider the statutory claim initially as a matter of pendant jurisdiction. Since that holding, the Court in Westby v. Doe, 420 U.S. 968 (1975), has made it clear that in a challenge to Medicaid provisions under Title XIX, the statutory claims must be carefully considered before the constitutional issues are reached. Accordingly, in the instant case, the Court will first consider whether the Virginia procedures complained of are consistent with the Social Security Act.

Plaintiff-intervenors seek class certification under Rule 23(a) and (b)(2), said class consisting of all recipients of benefits under the Virginia Medical Assistance Program. These intervenors being represented by counsel other than counsel for the original named plaintiffs are, in the Court's view, more appropriate class representatives, and concluding that the suit is an appropriate Rule 23(b)(2) class action, an order in this regard will follow.

The facts disclosed are that since 1969 Virginia has participated in the Federal Title XIX Medicaid program of medical assistance to certain categories of the needy. During the first five years of the program, the total cost of inpatient hospitalization care was covered. However, on January 15, 1975, the Commonwealth of Virginia instituted a 21-day limitation for a stay on Medicaid coverage. This amendment limiting reimbursement for inpatient care was

approved by HEW on June 13, 1975, along with other amendments or "cutbacks" in the State Plan. Notice of the amendments was given to the plaintiff hospitals as well as to other "providers", physicians, pharmacists and druggists by memoranda dated January 10, 1975. The facts reveal that individual Medicaid recipients were not given notice of the reduction in inpatient care although notice of the other cutbacks was given by form letter dated January 8, 1975.

The new 21-day limit on inpatient hospitalization care was based on estimates from state statistics for fiscal years 1973 and 1974 to the effect that approximately 92% of Medicaid hospital patients would be discharged within a 21-day period. HEW's own statistics approximate those of the state, in that 95.7% of Virginia Medicaid hospital patients were in fact discharged within 29 days.

Title XIX of the Social Security Act, 42 U.S.C. § 1396 et seq., provides for the establishment of cooperative federal-state programs, commonly called "Medicaid" "[f]or the purpose of enabling each state, as far as practicable under the conditions in each state, to furnish" medical assistance to certain needy individuals "whose income and resources are insufficient to meet the costs of necessary medical services." [42 U.S.C. § 1396] A large degree of discretion is afforded the state in tailoring its program to the needs and conditions therein prevailing. Among the options available are the option to cover only the categorically needy, 42 U.S.C. § 1396(a)(13), the option to limit the categorically needy to five basic types of services including inpatient hospital services, §§ 1396a(a)(13)(B) and 1396(d)(a), options on services to be provided the medically needy¹ if they are included, § 1396a(a)(13)(c), and discretion as to eligibility standards, § 1396a(a)(7), among others. It is required, however, that the State Plan be consistent with

the federal statute and implementing regulations in order to receive federal funding.

Plaintiffs contend that Virginia's "21-day limitation" on coverage of inpatient hospital services violates several requirements in Title XIX and the implementing regulations.

Specifically, plaintiff providers and recipients contend that the limitation violates requirements that the State Plan provide (1) equal benefits to all similarly situated Medicaid recipients, § 1396a(10)(B)(i)(ii) and C(ii); (2) for payment of the reasonable cost of inpatient hospital services, § 1396a(a)(13)(D); and (3) that categorically needy recipients may not be forced to share in the costs of any of the mandatory services, including inpatient hospital care, § 1396a(a)(14)(A)(i). However, these requirements apply only to medical assistance which is provided under the State Plan and do not define what the extent of the original coverage must be. Since inpatient hospital services beyond 21 days are not provided under the Virginia State Plan, the failure to provide coverage for those recipients requiring longer hospital stays does not violate these provisions of the Act.

The essence of the instant issue is whether a state plan may, in the first place, limit coverage of inpatient hospital care. The statutory analysis must begin with a recognition that the federal law gives each state great latitude in dispensing its available funds. The purpose of the Act was to enable states "as far as practicable" (42 U.S.C. § 1396) to provide medical assistance to the needy. Medical assistance is defined in § 1396d(a) as "payment of part or all of the cost" of services provided.

Pursuant to the federal regulations promulgated under the Act, a state plan must

"[s]pecify the amount and/or duration [of medical services] . . . Such items must be sufficient in amount, duration and scope to reasonably achieve their purpose. With respect to the required services . . . the state may not arbitrarily deny or reduce the amount, duration, or scope of, such services to an otherwise eligible individual solely because of the diagnosis, type of illness or condition." (Emphasis added) 45 C.F.R. § 249.10(a)(5)(i).

It is the position of the plaintiffs that this regulation creates two criteria which they contend are violated by the defendants. The services provided must be sufficient in amount, scope and duration to reasonably achieve their purpose and the state may not arbitrarily deny or reduce the amount, duration and scope of required services to the categorically needy because of a condition.

The Department of Health, Education and Welfare has interpreted this regulation to mean that services provided reasonably achieve their purpose if the amount, scope and duration would be sufficient for most of the persons needing that type of care.

"For example, if a state wishes to limit days of hospital care per year, the number of days should be at least adequate to cover one admission for the average days needed by those individuals covered under the program." HEW Field Staff Information and Instruction Series: FY-76-62 at p. 7 (Jan. 2, 1976).

From the inception of Title XIX, HEW has approved state plans providing coverage of inpatient hospital services for a limited duration. According to state plans on file as of September 2, 1976, eighteen states placed some absolute limit on number of days of coverage of inpatient hospital services.

It is well settled that the agency charged with the administration of a statute is entitled to have its interpretation of the statute given great weight by the courts. New York State Department of Social Services v. Dublino, 413 U.S. 405, 421 (1973); Rat Lion Broadcasting v. FCC, 395 U.S. 367, 381 (1969). The test, of course, is whether the interpretation

is "reasonably related" to the purposes of the Act. Johnson's Professional Nursing Home v. Weinberger, 490 F.2d 841, 844 (5th Cir. 1974); see also Mourning v. Family Publications Services, Inc., 411 U.S. 356, 369 (1973).

Notice

Plaintiff-intervenors, representing the class of Medicaid recipients, further contend that the reduction in Medicaid hospitalization benefits without prior written notice to recipients or opportunity for a hearing was in violation of federal regulations and a contention with which the Court agrees. HEW has promulgated rules and regulations requiring "timely and adequate" notice to Medicaid recipients by the states prior to a reduction in assistance.

Title 45, Code of Federal Regulations, Section 205.10(a)(4)(i) provides that:

"(4) In cases of intended action to discontinue, terminate, suspend or reduce assistance:

(i) The State or local agency shall give timely and adequate notice, except as provided for in paragraphs (a)(4)(ii), (iii), or (iv) of this section. Under this requirement:

(A) 'Timely' means that the notice is mailed at least 10 days before the date of action, that is, the date upon which the action would become effective.

(B) 'Adequate' means a written notice that includes a statement of what action the agency intends to take, the reasons for the intended agency action, the specific regulations supporting such action, explanation of the individual's right to request an evidentiary hearing (if provided) and a State agency hearing, and the circumstances under which assistance is continued if a hearing is requested."

No such notice was given to recipients with regard to reductions in inpatient hospital services although notice of other reductions in services was given dated January 8, 1975.

State defendants contend that such failure to provide notice has now been rendered harmless error. They seek to draw the Court's attention to numerous newspaper articles published throughout Virginia during the month of January,

1975, informing the public of the change in the Medicaid policy concerning reimbursement for inpatient hospital services. Additionally, they contend that notice of the reduction, dated January 16, 1976, was given to all local welfare departments who are responsible for enrolling and renewing eligible recipients. Further, it is their contention that an updated pamphlet informing Medicaid recipients of all services covered by the Plan, including the limits on reimbursement for inpatient care and services was distributed to virtually all Medicaid recipients by January, 1976.

None of these proposed substitutes for individual notice meet the timeliness requirement for notice under 45 C.F.R. § 205.10(a)(4)(i)(A), which requires notice to be mailed at least 10 days before the date of action, which in the instant case was January 15, 1975.

As to the adequacy of the contended substitutes, this Court cannot in good conscience take judicial notice of the accuracy or completeness of newspaper articles regardless of the diligence and good intentions of the writers thereof, nor can it accept the "trickle down" effect of providing notice to the local welfare departments in a vague hope that the word will be passed along to Medicaid recipients. Nor can the pamphlet describing available Medicaid services, not fully distributed until one year after the reduction of inpatient hospital care serve to notify recipients of a reduction in services. The regulation regarding adequacy of notice is appropriately specific. It requires that written notice be given that includes (1) a statement of what action the agency intends to take, (2) reasons for the intended agency action, (3) specific regulations or change in law requiring such action, and (4) a statement of the circumstances under which a hearing may be obtained and assistance continued. 45 C.F.R. § 205.10(a)(4)(i)(B) and § 205.10(a)(4)(iii).

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The importance of prior and adequate notice before public assistance is reduced or terminated has been stressed in a number of cases including Goldberg v. Kelly, 397 U.S. 254 (1970), the fountainhead for procedural due process rights of welfare recipients. Such notice requirements are applicable to across-the-board reductions as well as to individual reductions. Rochester v. Baganz, 479 F.2d 603 (3d Cir. 1973); Velazco v. Minter, 481 F.2d 573, 579 (1st Cir. 1973), Jennings v. Solomon, No. Y-75-1869 (D.Md. Nov. 4, 1976); Benton v. Rhodes, No. 76-263 (S.D.Ohio May 11, 1976); Robinson v. Maher, No. H-76-1 (D. Conn. Jan. 19, 1976).

The importance of prior notice to recipients was stressed by HEW and reiterated by the Court in Rochester v. Baganz, supra at 606-607.

"The secretary urges that even in cases of across-the-board reductions such advance notice is necessary, or at least appropriate, for the orderly administration of welfare programs. He urges that in a program designed to meet subsistence needs recipients ought to be informed in advance if their payments are to be cut for any reasons, so that they may be able to plan for the cut, and to the extent possible adjust to it. We agree that it was well within the range of the Secretary's rulemaking authority to insist, as a condition for state participation in the AFDC program, that each state manage its fiscal affairs so as to be able to provide at least this minimum advance warning to beneficiaries about to be deprived of benefits upon which they may have been counting heavily."

This same concern was recently repeated in the HEW Field Staff Information and Instruction Series FY-76-62 Jan. 2, 1976, Part IV, Fair Hearings at p. 13 which provides:

"Whenever a State intends to take action to discontinue, terminate, or reduce the amount of medical assistance provided eligible individuals, . . . or to make changes in coverage which would terminate eligibility for some individuals, timely and adequate notice of such intent is required to be sent to all recipients in accordance with 45 C.F.R. 20.10. Because of the consideration being given

currently by a number of States with fiscal difficulties to reductions in this Medicaid program, it is important that this step in the process of State plan amendment not be overlooked, (Emphasis added.)

It follows, therefore, that the Court must conclude that "notice" allegedly given to recipients in the instant case was neither timely nor adequate, and thus contra to federal law.

Hearing Plaintiffs contend that in addition to prior and adequate notice, Medicaid recipients are entitled to a hearing before their benefits are reduced. This contention requires a more difficult and complex analysis under the applicable regulations. 45 C.F.R. § 205.10(a)(5) provides:

(5) An opportunity for a hearing shall be granted to any applicant who requests a hearing because his claim for financial or medical assistance is denied, or is not acted upon with reasonable promptness, and to any recipient who is aggrieved by any agency action resulting in suspension, reduction, discontinuance or termination of assistance. A hearing need not be granted when either State or Federal law require automatic grant adjustments for classes of recipients unless the reason for an individual appeal is incorrect grant computation. (Emphasis added.)

At first blush, the regulation seems to exempt across-the-board reductions or "adjustments" from the mandatory hearing requirement. Plaintiffs argue, however, that there is a distinction between reductions resulting from "agency policy" and reductions resulting from "changes in State or Federal law." The argument is bottomed on the "legislative" history of the regulations regarding hearings and the regulatory scheme as it currently exists.

When first published in the Federal Register for comment, 38 Fed. Reg. 9820 (April 20, 1973), the proposed regulations provided that hearings on issues of policy only, must be granted to individuals "unless there is made available an alternative procedure whereby views concerning state agency policy can be communicated to officials of the State

agency." § 205.10(a)(3) (as proposed). This provision, however, was deleted from the final regulations in response to comments that "the hearing procedure provides a viable mechanism for effecting changes in policy." 38 Fed. Reg. 20006, para. 5 (Aug. 15, 1973).

In a recent case, Jennings v. Solomon, No. Y-75-1869 (D. Md. Nov. 4, 1976, the Court found this argument to be without merit since there is "no sensible way of distinguishing between 'agency policy' and 'State law'; when agency regulations are validly promulgated pursuant to legislative authority, they have the force of law." (at p. 11) However, in Benton v. Rhodes, supra, the Court found that recipients were entitled to hearings in across-the-board Medicaid cutbacks.

The purpose of the notice and hearing provisions, as revealed by their history, was to give recipients the opportunity to participate in the decision-making process when a reduction was made by the administrative agency based on policy considerations. By contrast, when a reduction is automatically required by law, such as an act of the legislature, an administrative hearing would be an act of futility.

The distinction between "policy" and "law" is further borne out by the current regulatory scheme. On three occasions, the regulations group together adjustments required by law with those the result of policy decisions, 45 C.F.R. §§ 205.10(a)(5)(iv); (a)(6)(i)(A) and (a)(7). In three other places, the reference is solely to state or federal law. 45 C.F.R. §§ 205.10(a)(4)(iii), (a)(5) and (a)(5)(v). HEW could hardly have intended this thrice repeated distinction to be inadvertent. Furthermore, the references solely to state or federal law are made in the context of exemptions from the hearing requirement, 45 C.F.R. §§ 205.10(a)(5) and (a)(5)(v), whereas the occasions

where reference is made to both law and policy, it is in the context of permitting the agency to consolidate individual requests for a hearing into a single group hearing, § 205.10(a)(5)(iv), or to reduce assistance in the interim between the hearing and the decision, §§ 205(a)(6)(i)(A) and (a)(7).

To summarize, the Court is satisfied that the language and history of the regulations demonstrate the intention to provide for participation by recipients in the decision-making process for policy changes in the Medicaid program.

In considering the relief to be afforded, it should be noted that the Eleventh Amendment to the Constitution of the United States granting states sovereign immunity is no impediment to the Court's entertaining plaintiffs' claims for declaratory and prospective injunctive relief against the defendant state officers. It is also to be borne in mind that the Eleventh Amendment does bar retroactive relief under Edleman v. Jordan, 415 U.S. 651 (1974).

In determining the grant or denial of a preliminary injunction, the Court has the duty and burden of balancing several conflicting values -- "the threat of irreparable injury to the plaintiff should preliminary injunctive relief be denied; injury to other parties should the injunction issue; the probability that the plaintiff will succeed on the merits; and the interests of the public." Conservation Council of North Carolina v. Costanzo, 505 F.2d 498, 502 (4th Cir. 1974); Long v. Robinson, 432 F.2d 977, 979 (4th Cir. 1970).

As the Court has already noted, the Eleventh Amendment bars retroactive recovery by provider hospitals and Medicaid patients of the costs of hospital care beyond 21 days, the

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plaintiffs will be left without a remedy for any injuries sustained prior to trial on the merits, absent the granting of the instant relief sought. The defendants, on the other hand, are in a far different position, for if the preliminary injunction issues and the defendants ultimately prevail at trial, recoupment may be made of any monies paid to plaintiff hospitals as a result of the injunction simply by deducting the amount from the next Medicaid payment due the hospitals. The evidence adduced satisfies the Court of the practicability of any such eventuality. Thus, with regard to irreparable harm, the balance of hardships tips decidedly toward the plaintiffs.

Procedural
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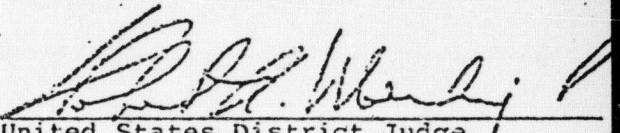
Additionally, the Court concludes that the plaintiff-intervenors would more probably succeed at trial on their statutory claim to prior notice and a hearing. Neither timely or adequate notice nor the right to a hearing as required under 45 C.F.R. § 205.10 were afforded Medicaid recipients, prior to the reduction in their benefits under the Social Security Act.

The final element to be considered by the Court is the interest of the public. The Court is satisfied that the public interest requires the enforcement of the requirements of federal law and regulations to carry out the congressional purpose in the enactment of Title XIX, Medicaid, which was to provide medical assistance to certain needy individuals.

Concluding therefore that the balance of hardships, the likelihood of success on the merits on the statutory due process claims, and the public interest are all strongly in the plaintiffs' favor, it follows that a preliminary injunction must issue. This Court has the power and indeed the duty to prohibit the state's use of federal funds in a manner incompatible with federal law. See Rosado v. Human, 397 U.S. 397 (1970).

In light of the Court's conclusions reference the plaintiff-intervenors' statutory due process claim and further in light of the fact that issues remain as to the "reasonableness" of Virginia's 14/21 day limitation on inpatient hospital care under 42 U.S.C. § 1396(a)(17) and 45 C.F.R. § 249.10(a)(5)(i), coupled with the fact that plaintiffs have also alleged constitutional violations upon which the Court has not yet had the opportunity to rule, it follows that the defendants' motions for summary judgment must be denied.

An appropriate order will issue.


United States District Judge

Date: DEC 3 1976

FOOTNOTE

1. Categorically needy and medically needy are defined in 45 C.F.R. § 248.10(a)

(1) The term "categorically needy" refers to an individual who is receiving financial assistance under the State's approved plan under title I, IV-A, X, XIV or XVI of the Social Security Act, or is in need under the State's standards for financial eligibility in such plan.

(2) The term "medically needy" refers to an individual whose income and resources equal or exceed the State's standards under the appropriate financial assistance plan but are insufficient to meet his costs for medical insurance premiums and for necessary medical and remedial care and services recognized under State law but not encompassed in the State plan for medical assistance, plus his costs for medical and remedial care and services included in the State plan.

3 Copies Received
March 25, 1977

4:45 P. M.

Louis J. Lepore

Attorney General

Attorney for Agell

By George J. Mantour General
Prosecutor Attorney